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Events and Comments

Rehabilitation Literature is intended for use by professional personnel and students in all disciplines concerned with rehabilitation of the handicapped. It is dedicated to the advancement of knowledge and skills and to the encouragement of cooperative efforts by professional members of the rehabilitation team. Goals are to promote communication among workers and to alert each to the literature on development and progress both in his own area of responsibility and in related areas.

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REHABILITATION LITERATURE

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Dr. Stella Chess Comments on

Behavioral Disorders Due to Brain Damage

"SEVERAL DECADES AGO, the brain-damaged child was treated only for the organic components of his illness, generally by the pediatrician or the neurologist, and no attempt was made to deal with the behavioral components. The diagnosis and treatment of the organic disease seemed all that could be done for him. Today, child psychiatrists are more optimistic that something can be done to alleviate the behavioral difficulties. This change of attitude has come about to some extent through better understanding of the course of diseases of the brain, but chiefly through the development of new treatment techniques. . . .

"We are indebted to Lauretta Bender for some of our optimistic concepts about the treatability of brain-damaged children and to Kurt Goldstein for detailed studies of rehabilitation procedures for them. Successful work with these youngsters is based on the premise that hyperactivity which cannot be eliminated can at least be channeled. The child who has been unable to function in normal society because of his impulsiveness can make a better adjustment if both he and those around him learn to recognize incipient signs of uncontrollable restlessness and if a constructive or at least bearable outlet for his impulses is provided. When this procedure can be followed, secondary symptomatology such as negativism or hostility can be altered or kept to a minimum.

"The aim of psychiatric treatment for the brain-injured child is to help him take his place in normal society insofar as his handicap permits. . . . Attempts to provide a normal environment and normal contacts for brain-injured children often fail because of social attitudes. Chief among the deterrent factors is the litigation-consciousness of our present society. Many educational and recreational institutions and organizations hesitate to accept a child who is known to have a convulsive disorder lest an injury to him expose them to a lawsuit based on a charge of neglect. Similarly, a child who is known to be hyperactive and impulsive is unwelcome in supervised group activities of normal children since those in charge fear that his accidental injury of another child may lead to a lawsuit. These and many other factors over and above the brain-damaged child's own capacities must be taken into account in attempts to provide a normal environment. . . .

"Treatment efforts are directed toward helping the child gain a clear concept of the nature and degree of his handicap in terms of his chronologic or mental age, and an understanding of his own capacity—what situations he himself can handle and what situations warrant a request for aid from others. . . . The most favorable results in treating brain-damaged children are frequently obtained by the combined use of medication, guidance, and psychotherapy. . . ."

Mental Retardation with Behavior Disorder

"IN A WORLD organized for the average individual but willing to give admiration to, and make provision for, the intellectually gifted, the retardate has no place of dignity. With his entrance into the world of his peers, the social meaning of his slowness begins to take form. Even if he escapes being made fun of in his preschool years, his inability to keep up in the area of formal learning will make him a target for jeers in the classroom. Even if he safely makes the transition to the special class for Children of Retarded Mental Development (CRMD), he finds that the other children have their own title for it: the 'Class for Ready-Made Dopes.' The reluctance of parents to accept an intellectual handicap may keep the retardate from joining groups made

(Continued on page 383)

REHABILITATION LITERATURE

Article of the Month

The Habilitation Role of the Special Educator

Herbert Rusalem, Ed.D.

About the Author . . .

Dr. Rusalem, currently director of student personnel services, Hunter College, N.Y., received his Ed. D. degree in 1951 from Teachers College, Columbia University. After being a teacher, counselor, and administrator, Dr. Rusalem became a lecturer at Teachers College, associate professor of education and psychology, Long Island University, and professor of education, Yeshiva University. Recent research activities include: A Study of the Rehabilitation of the Older Disabled Worker (for Federation Employment and Guidance Service); A Study of Rehabilitation Problems Associated with Sound Localization and Other Hearing Losses Among Blind Persons (for Industrial Home for the Blind); and A Study of the Educational Achievement and Adjustment of the Evening Undergraduate College Student (for Hunter College). He is the author of the book Studies in the Vocational Adjustment of Deaf-Blind Adults and is now completing two books on special education and rehabilitation. Dr. Rusalem edits the "Research in Review" column of New Outlook for the Blind.

This original article was written especially for Rehabilitation Literature.

Special education is one of the less familiar disciplines associated with the rehabilitation team. In fact, more often than not, the special educator is accorded a second-class status in interdisciplinary relationships. The reasons for this are many. As a group, special educators are not altogether prepared for their teamwork role, their contributions tend to be minimized by other disciplines, and, because of their day-long assignments with disabled children, special educators rarely have the time for even the minimum level of participation and communication demanded by interdisciplinary cooperation. Insofar as the role of the special educator is constricted by the lack of understanding on the part of other professions, it can be corrected. The major objective of this paper is to contribute to this understanding by discussing the unique habilitation role and contribution of the special educator.

Special education is concerned with children and youth who, owing to intellectual, physical, and emotional limitations, would suffer educational deprivation if exposed exclusively to current general educational practices. The caseload of the special educator consists of individuals who require one or more adjustments in their educational programs, without which the growth process would be hindered. These adjustments vary in scope and intensity. At their least, they include remedial work within the framework of the regular public school class. At their most, they provide for the removal of the child into an entirely new environment that can be tailored to meet his individual needs. The settings of special education range from the regular public school class through special classes in the public schools to special day schools and residential institutions.

Educational service to disabled children differs from rehabilitation service to most disabled adults in one major respect. The latter has restorative connotations. Special education is developmental. Much of rehabilitation focuses upon assisting the individual to make optimum use of residual capacities, always keeping in mind that, in most cases, the person

was once intact and lived as a nondisabled person. On the other hand, most disabled children and youths have no past as nondisabled persons. They will continue to grow as impaired organisms. Whitehouse[1] and others have differentiated these two groups, calling the latter the "habilitation" population. This characteristic of disabled children and young people creates major differences in emphasis and approach and forms the base point for the habilitation role of the special educator.

Special Functions of the Special Educator

Many rehabilitation workers are inclined to view the special educator as undistinguishable from other teachers except that he works with disabled children. They see him as performing the essential teaching role of training children in tool subjects, passing on the cultural heritage, and encouraging them to learn the facts, concepts, and values of our society. The view of the special educator as just another teacher with an overlay of special understandings and technics is an incomplete one. The special educator has a habilitation role that encompasses much more than the customary subject matter of the various grades and a few special methods to help make this subject matter more accessible to children. In fact, the special educator is a rehabilitation worker of the first importance, with the emphasis being placed upon habilitation.

An article, however lengthy, cannot fully explore the ramifications of this role. As a result, the goal of this paper will be limited to highlighting a few of the special functions of the special educator, above and beyond the common team perceptions of his contribution.

Diagnosis of Experience Deprivation and Provision of Essential Life Experiences

Human development is a consequence of learning and experience. Disruptions in the flow of normal experience lead to disruptions in development. One major cause of impaired experience is disability. When this occurs, it may be expected that certain essential life goals appropriate for the individual at his stage of development will be thwarted. This thwarting will have important consequences for subsequent development. The Committee of Human Development[2] at the University of Chicago has formalized this construct in its concept of the "developmental task."

> A developmental task is a task which arises at or about a certain period in the life of the individual, successful achievement of which leads to his happiness and to success with later tasks, whereas failure leads to unhappiness in the individual, disapproval by society, and difficulty with later tasks. . .

The developmental tasks of young people are much the same for all—disabled or not. Typical ones include learning to talk, to control the physical environment, to get along with others, to build a philosophy of life, and to establish career patterns. However, the disability often serves as a barrier to the successful completion of these tasks. Failure to complete them results in retardation and creates a need for remedial and therapeutic measures.

At best, corrective measures do not fully substitute for the original experience. In many instances, "catching up" is difficult, if not impossible. Thus, the habilitation role of the special educator is hygienic and preventive, as well as remedial. In terms of remediation, the special teacher, in cooperation with psychologists and other professional workers, determines areas of living in which the deprivation of experience has occurred. The effects of such deprivation are assessed and therapeutic programs are set in motion to overcome them. As a result, the special educator becomes a diagnostician, uncovering gaps in the life experience of children and establishing programs that, in their cumulative effect, may hasten the development of the disabled child and bring him closer to norms for his age. Such programs include remedial reading and speech, remedial assistance with activities of daily living that should have been learned at an earlier stage of development, and remedial counseling designed to elevate levels of interpersonal relationships to accepted standards.

Many disabled children and youths come to the special educator, having had disturbances in their pattern of developmental tasks. These disturbances may have had their roots in numerous causes. A few are parental and community attitudes; inadequate teaching; long periods of hospitalization, institutionalization, and overprotection; insulation from common activities; and impairments in sensory and mobility capacities. As a result, more than most teachers, the special educator is a specialist in remediation. Without such special assistance, retardation (social-psychological as well as educational) becomes cumulative. Thus, the special educator has the role of stemming the tide of impoverishment of experience and of accelerating learning, so that earlier lacks can be overcome to some degree. The remediation function has much in common with rehabilitation. In concentrated form, it telescopes a series of experiences to effect a rapid change in directions that should have been taken earlier in the normal course of growth. The hygienic function is somewhat different. It focuses upon the here and now. At his present level of age and physical development, the disabled child, as with all children, needs certain current life experiences to maintain himself. For example, he may need opportunities to work and play with others to establish a sense of his own identity and to move forward in the stabilization of his self-concept. Denied these experiences owing to limitations imposed upon him by the handicap, the disabled child may not achieve these essential developmental tasks.

The function of the special educator is to enrich the environment. He must provide the opportunities that other aspects of the student's life ordinarily would but now, owing to the effects of the disability, do not. The

teacher of the nondisabled may take for granted certain life experiences as the products of normal family and community interaction with the student. In the case of disabled children and youth, such assumptions are not uniformly tenable. Disability in a child often creates separations and maladaptations in family relationships. Some disabled children lack the physical capacities to reach out for certain experiences. Finally, emotional problems may limit student motivation to interact with the environment. Thus, the special class or school must offer an exceedingly broad range of experiences, leaving little to chance or to the community.

An example of this familiar to rehabilitation counselors is the alleged lack of readiness for vocational planning and adjustment on the part of some graduates of special education. Vocational readiness is the product of a complex developmental process, starting, as far as the school is concerned, with the nursery school and terminating only when formal education terminates. Much of vocational readiness stems from out-of-school activities. The nondisabled child prepares himself through such informal means as carrying out assigned household responsibilities, observing various workers on their jobs, participating in adult-supervised work projects, earning all or part of his allowance through his own services, holding down part-time, week-end, and summer jobs, and ultimately assuming a full-time employment status. These necessary steps are taken by many disabled youths. Among the severely disabled, however, progress through these steps is more difficult. Consequently, in the absence of community and family efforts to create opportunities for work experiences, the special educator must provide them. Often, in cooperation with rehabilitation services, the special teacher develops vocational guidance and training programs keyed to student needs. An outstanding example of this is found in the occupational education and related curricula developed for mentally retarded students.

Developmental Guidance

Rehabilitation practice generally focuses upon individuals who have achieved a measure of stability in their development. The rehabilitation population is often characterized by crystallized interests, full physical growth, and a more or less stable self-concept. Disabled children, on the other hand, are emerging individuals. They are in the process of becoming. Their capacities for growth are substantial. For them, habilitation can be an original learning process, rather than the relearning often demanded of rehabilitation clients. This quality makes for certain implications for the habilitation role of the special educator.

Since habilitation is developmental in character, the special educator is a participant in a process that spans the period of development. This period may extend from early childhood into the adult years. As a matter of fact, special education programs are reaching into the colleges and universities with increasing frequency. Unlike the typical rehabilitation process, habilitation covers periods as long as 15 or 20 years.

Over this period of time, physical, intellectual, and psychological changes associated with growth take place. As each developmental task is completed and the disabled student moves on to the next, new challenges appear. As Barker and associates[3] have indicated, the disability constitutes a permanent and impermeable barrier that cannot be disregarded for any length of time. Thus, among severely disabled children and youths, the disability barrier may serve as a source of frustration and developmental retardation at any point along the habilitation continuum. In rehabilitation, as a result of a relatively brief process, the disabled individual becomes increasingly self-directing and goes on to manage a more or less stable environment with a minimum of additional help. On the other hand, the disabled young person is confronted by a changing self and a changing social status, both of which are subject to the complex effects of disability. As a result, although he achieves an increasing measure of self-direction, the disabled young person requires continuing and persistent developmental guidance.

This guidance is not overwhelming, imposing itself upon the growing organism to perpetuate its dependency. On the contrary, its major goal is self-sustenance. In many cases, this is achieved early in the life of the disabled child and he moves on to meet life demands with a minimum of professional help. On the other hand, severely disabled children and youths, coping with inconsistent social attitudes, shifting demands, and physical,

A Comment on
The Teacher as Observer and Recorder

"A TEACHER HOLDS a unique position in relation to a deaf child. As a professionally trained specialist, he has more opportunity than a doctor, therapist or technician to really know the child. He observes and lives with his student for hours each school day; he works and plays, he excites and influences, he watches and helps. He reacts to his deaf pupil and is reacted to.

"In the eyes of some medical personnel, a teacher has little to offer in the total diagnostic process. Because the teaching profession has traditionally defined its objectives in terms of academic achievement, other specialists who contact deaf children often fail to ask the child's teacher, 'What have you seen this child do? What are his likes and dislikes? How does he react under pressure? How does he think?' "—*From "Diagnostic Teaching—The Teacher's New Role," by Leo E. Connor, in* Volta Review, *Sept., 1959, p. 311.*

intellectual, and emotional changes, often need help at critical points in their development. This is illustrated by the fact that a number of colleges and universities have found it desirable to offer special guidance services for disabled students. These constitute an attempt to provide continuity of guidance throughout the developmental period.

It is generally held that the teaching role and the therapeutic counseling relationship are incompatible when exercised by the same teacher. Even assuming this to be so, the special educator retains a vital guidance role. This role is expressed through providing essential information, interpreting the world to the child, providing him with reassurance and suggestions, assisting him to understand the human environment about him, serving as an adviser, interpreting his needs to other professional personnel, and serving as a bridge between the school and the parents.

In essence, the special educator is more often a guidance person than are other teachers. He must be sensitive to the guidance needs of the child at every stage of development, provide guidance and instruction at levels within his competency, and refer the student when guidance needs at other levels appear. The referral function brings the special educator into close relationship with members of other professions and superimposes upon him a teamwork role that cannot be ignored by other team members.

Coordination of Habilitation Program

Habilitation and rehabilitation programs are generally complex organizations of services and personnel requiring coordination to insure wholeness, consistency, and mutual goals. In a medical setting, the coordinative function is exercised by the physician. In a state rehabilitation agency, the rehabilitation counselor coordinates the program. Most habilitation takes place in an educational environment. Under these circumstances, the coordinative function falls to the special educator. This is exemplified in the cerebral palsy units found in some public school systems. These units integrate teaching, physical and occupational therapy, medicine, guidance, clinical psychology, and social casework into a single comprehensive service. Generally, special educators coordinate these programs.

In an educational setting, the habilitation program flows out of the classroom. Since the child spends the greater proportion of his time with the special teacher, this endows the latter with opportunities to know him, to understand his needs, and to plan his schedule. In many instances, the fruits of habilitation are first observed in classroom behavior. In addition, the observational and performance data provided by the special teacher are essential ingredients in the diagnostic activities of the team. In some cases, the special educator becomes the team coordinator by default. However, the realities of the educational situation are such that this function would normally be assumed by the teacher.

Thus, special educators fill the coordinative role in habilitation through scheduling, through establishing and maintaining the team's communication network, and through assuming responsibility for the over-all growth of the child. Members of one profession or another often state the case for team leadership's being assigned to their profession on the basis of their unique understanding of the whole person. In a school program, the special teacher can offer similar logic to support his role as coordinator of the habilitation process.

Promotion of Integration Activities

During the first half of the 19th century, special education in the United States was a segregated service. In the beginning, blind and deaf children were invariably educated through residential institutions. Graduation from these institutions sometimes led to a lifetime in a sheltered workshop or an asylum. Since then, American educational values have changed. The goals for exceptional children and youth are integrated ones, wherever possible. Today, even blind and deaf children are being served in the regular public schools, often in regular classes for nondisabled students.

By its very nature, special education is segregative. Even the most modest special education service temporarily removes the child for some period of time from the normal educational environment and, through class placement, equipment, methods, or program, differentiates him from others. In effect, this is comparable to rehabilitation, in which the special environments of the hospital, rehabilitation center, training institution, or workshop are introduced temporarily to effect subsequent adjustment and integration. It is temporary segregation used as a rehabilitative and habilitative device to achieve subsequent integration. Thus, the special educator has the role of promoting integration into normal living through judicious and professional use of a controlled and, to some degree, segregated environment.

Special educators use a variety of educational settings to promote habilitation. These range from highly segregative residential institutions to more integrated public school classes. In a sense, environmental manipulation is a major instrument of habilitation used by special teachers. Disabled children need all degrees of special environment. Some may never achieve full integration. Others, through progressing from one level to the next, may be habilitated into full integration.

The function of the special educator is to use any given educational environment to promote student growth and to prepare him for the next degree of integration. Thus, the special educator holds the key to one of the most significant areas of movement for children and youth. In consultation with physicians, psychologists, and others,

they ascertain the degree of integration that is currently most consistent with the individual's needs. Having done this, they proceed to plan and implement an educational program that, in the course of habilitation, will increase student readiness for the next level of integration.

This function has much in common with counseling, the objective of which is to help the counselee to function without further assistance from the counselor. Special education aims at assisting students to develop in such a way that they will require as little future special education as possible. Thus, special educators retain students, not for any fixed period of time, but for only so long as the special education service is desirable. When other settings appear to hold greater promise for student growth, a transfer to them is effected. Thus, the special educator holds a central role in the progress of disabled students toward increasing "normalcy" of educational setting. Since integration into society is a primary goal of habilitation, wherever possible, the special educator is a focal figure in the habilitation of disabled children and young people.

Purveyance of Reality Standards

Many rehabilitation counselors are familiar with certain graduates of special education programs who reveal unreal concepts of the world of work and its demands. These may be expressed in terms of salary level desired, working conditions requested, type of supervision that they believe they should receive, the relationship between speed of performance and quality of product on a job, and the types and degrees of special considerations that should be expected. Frequently there is great disparity between the student's concepts of these factors and the reality of the work situation.

Actually, this is only one area in which reality standards and norms constitute problems for exceptional children and youth and those who work with them. In fact, one of the basic tasks of habilitation is helping the student to share the reality field of the professional worker. Assuming that the frame of reference of the professional worker reflects the societal norm, any failure on the part of the student to recognize and accept it is likely to constitute an additional barrier to effective social relations, vocational success, and mental health.

In effect, the point of discussion is not conformity. In weighing the realities of any situation, the disabled student may decide to conform or not, taking the social consequences that flow from his decision. On the other hand, if nonconformity is built upon a substructure of lack of understanding of the reality, the student really does not have an opportunity to make such a decision. Often, a number of factors combine to shield the disabled student from reality. The attitudes of parents, the social segregation of certain types of educational arrangements, the emotional withdrawal of the student, the inability to move out into the community to test his ideas and capacities, and the admonitions of some physicians and other professional workers may play a part in stimulating unreal thinking.

In some respects, the special educator is an equalizer. His function has come into being because educational opportunities for exceptional children are limited in general educational settings. Thus, a new and more productive educational reality is to be created through which more equal chances will be available. Almost by its very nature, special education is unreal, at least to the degree that it modifies the more common reality of regular school activities. Yet, this unreality may contribute to ultimate handicap. As a result, the special educator takes on the responsibility of functioning in an unreal school environment but minimizing its effects.

The methods used by the special educator are numerous. Educational adjustments made necessary by the disability are kept to the absolute minimum. Those that are made are within the framework of existing general practice. Thus, individual instruction is given the homebound child, but the levels of achievement demanded of him are in the framework of expectations of all students at his level of attainment. Some disabled students may not be able to take important field trips. However, the substance of these field trips is made available to them through vicarious means.

One additional reality-promoting mechanism used by special education is of great importance. Even though special educational adjustments are necessary, as many educational activities as possible are conducted alongside nondisabled students. For example, blind students must use Braille instead of inkprint for reading. Yet, through brailling typical textbooks, it becomes possible for the blind student to attend many regular classes at all educational levels. The mentally retarded are another instance. Even though a special curriculum is required, assembly programs, physical education, and shop subjects may be taken with other students.

Much of the success of subsequent rehabilitation rests upon the reality that the exceptional youth brings with him into the adult rehabilitation process. If this reality is grossly inconsistent with the demands of adult social life and work settings, his difficulties will be multiplied. If, on the other hand, the special educator has been able to introduce a sense of reality into the learning of the student despite the measure of unreality of special education, the odds are more nearly in favor of the student. This reality function influences the success and failure of all other aspects of the habilitation program. As a result, the special educator becomes a key person on the team.

Five habilitation areas were noted above: 1) the diagnosis of deprivation of experience and the provision of essential life experiences; 2) developmental guidance;

3) coordination of the habilitation program; 4) promotion of integration activities; and 5) purveyance of reality standards. These areas have important implications for the functioning of the special educator on the (re)habilitation team. As such, they are a concern to professional workers everywhere who serve exceptional children.

Factors Affecting the Special Educator Functioning on the Rehabilitation Team

It is suggested that the special educator has an essential role to play in habilitation, that he will be a member of the habilitation team, and that we should explore means of working closely with him. Some of the implications in this connection are presented below.

Recognition of Status

Effective team cooperation with special educators requires a recognition and acceptance of their status. Tolerance of their presence will no longer suffice. It is essential that they be recognized for what they really are: trained specialists in general and special education, with a unique role to play in the habilitation that does not duplicate or broadly overlap the roles of other professionals. In general, they have one capacity that no one else on the team possesses. They are the most competent individuals in the art and science of teaching.

It almost seems to be redundant to note this. Yet, in many instances, this special area is either ignored or overlooked. For example, educational and clinical psychologists, on the basis of their findings, tend to tell teachers how to teach a child. Not infrequently, special educators find these suggestions totally unreal and impractical. Furthermore, these specific instructions constitute a lack of appreciation for the skill of the teacher. The teaching capacities of psychologists would soon become apparent if they spent a week or two in the classroom with the children, as teachers do. Respect for the teaching profession is manifested through making available to them the best data we can submit. Then, teachers are capably trained to make essential curriculum and methodological decisions. At times, physicians, counselors, and social workers are guilty of the same practice of telling how to teach the child. Effective teamwork with teachers can best be built upon mutual respect for professional competence. Usurping their function is potentially damaging to the student and to the special teacher's maximum contribution to the team.

Better Habilitation Training for Special Educators

Some special educators perceive themselves as having inferior team status. In part, this is due to the reactions of other professionals to them. However, some measure of it results from their own inadequate preparation for the teamwork function. In this regard, teacher training institutions can improve the preparation of special educators by: 1) providing courses that specifically instruct in habilitation functions; 2) being increasingly selective in admitting candidates to this exacting field; 3) providing special teachers with training in group dynamics and teamwork; 4) exposing special teachers to teamwork situations with other disciplines. For example, at Teachers College, Columbia University, some special education students take one or more interdisciplinary rehabilitation courses.

Eradication of Artificial Lines Separating Special Education, Habilitation, and Rehabilitation

Currently, rehabilitation as practiced in state agencies reaches down to age 14. Special education reaches up to the completion of formal education, but no farther than the termination of graduate study. Habilitation is still an amorphous term that has no official status and is used to describe a variety of different situations. Through custom, legislation, and concept, the three terms—habilitation, rehabilitation, and special education—tend to connote three different aspects of human service although the areas cannot be precisely identified.

As a group, special educators have tended to identify themselves as educators rather than as rehabilitation workers. This position is valid, but partialistic. The earlier discussion on the habilitation role of the special educator suggests that, in addition to the basic teaching function, special educators are also rehabilitation specialists. Their concern with medical problems, comprehensive habilitation programs, interdisciplinary teamwork, coordinated community efforts, and the broad area of student adjustment brings the special educator into the area of rehabilitation. He straddles two major fields, with one leg firmly planted in rehabilitation.

On this basis, the line between special education and rehabilitation blurs. This is not unique. Physicians are similarly concerned with diagnosis, treatment, education, and research, as much as they are with rehabilitation. Many professions straddle several fields, with rehabilitation as one of them. Insofar as special education participates in the rehabilitation process, it is a rehabilitation profession. Perhaps the time is not long coming when special educators will more frequently perceive themselves and be perceived as rehabilitators. For example, it would be appropriate to see a special education section in the National Rehabilitation Association and other professional rehabilitation groups. Just as special education in its teaching aspects is a special instance of general education, so is it in its habilitative aspects a special instance of rehabilitation. It is felt that the eradication of these artificial lines will have the practical consequence of better integrating the special educator into the rehabilitation team and making rehabilitation service available to all, regardless of classification by age.

The differentiation between the terms rehabilitation and habilitation is sound. Semantically, it would be

operationally more useful if both rehabilitation and habilitation were components of a larger term that would be inclusive of both. However, this is not the case. The more general term is rehabilitation. Habilitation is a specific limited instance of rehabilitation. Since the term rehabilitation is likely to endure as the comprehensive term by reason of its place in legislation, the literature, and commonly accepted concepts, it would seem that, for most practical purposes, it should be used with persons of all ages, whether they have ever been nondisabled or not.

There was a time when the "re" in rehabilitation had a sharp meaning. It indicated the need to return an adventitiously disabled person to an earlier nondisabled status. This meaning has long since been obliterated. The goals of rehabilitation are not restorative in the narrow sense of the word. In many instances, the objective is helping the disabled person develop a new pattern of living. Many workers in the field recognize that there is no turning back. The experience of being disabled creates many lasting changes in human circumstances. Often there is no return to the past. The problem is that of finding a new way of life. Some of the components of this way of life may be threads of the premorbid pattern, but essentially the configuration is a new, and hopefully, satisfactory one.

Except for technical discussions, it would seem wise to blanket habilitation and special education under the term rehabilitation. Some movement in this direction is already evident. For example, the term rehabilitation is now widely used in reference to children. Furthermore, the title of the bibliographical magazine in our field is *Rehabilitation Literature,* covering all age groups and settings. In concept as well as in words, it seems advisable to perceive all special educators, habilitators, and rehabilitation workers as participants in a single field, a field that serves exceptional persons of all ages and that is bound together by the philosophy of rehabilitation.

Development of Rehabilitation Legislation for Disabled Children and Youth

Currently, federal and state rehabilitation legislation does not apply to children and youths under age 14 or 16. This legislation has imperfections, but it also has exceedingly positive aspects and a great promise for the future. Efforts are now underway to amend the federal law to broaden and deepen its impact upon rehabilitation in general. Whatever shortcomings this legislation may have, it has the merit of providing consistency, funds, and structure to the rehabilitation efforts of the several states.

On the other hand, legislation for disabled children is a patchwork of federal, state, and local enactments without apparent order or direction. As far as the educational aspects of special education are concerned, the leadership of the U.S. Office of Education and the state departments of education is satisfactory. However, the rehabilitation aspects of special education are subject to varying provisions and administrations. Often, crippled children's acts, departments of health, departments of welfare, social security agencies, and others contribute to a sprawling and not altogether complete service.

Disabled children need rehabilitation service. They can benefit from physical restoration, vocational guidance and training, assistance with the activities of daily living, scholarships, research, and other related services. These are comparable in many respects to the rehabilitation services provided to adults. As a matter of fact, we already have evidence of the value of a coordinated rehabilitation approach to exceptional children. Some state rehabilitation agencies have comprehensive programs for students in secondary schools. These programs have served as invaluable adjuncts to the special education offerings at this level.

Until now, the rehabilitation emphasis has been upon adults. In the face of the current need, there seems to be persuasive evidence that additional legislation dealing with the rehabilitation of children would be exceptionally helpful. As time goes by, it may be expected that national and state agencies will be giving additional thought and study to this possibility. At this point, disabled children and youths who could benefit from integrated rehabilitation programs supported by public funds are not always obtaining these services. The legislation that has worked so well for out-of-school disabled persons seems to hold promise for children and youth, as well.

From an examination of the habilitation role of the special educator, four implications have been drawn for rehabilitation practice: 1. Special educators have a need for recognition and status on the rehabilitation team. 2. They have a need for better training in the area of habilitation. 3. It is desirable to eradicate the artificial lines separating special education, habilitation, and rehabilitation. 4. Service to disabled children and the contribution of the special educator will be enhanced by the development of rehabilitation legislation for disabled children and youth.

Through better integrating the special educator into the rehabilitation team and making it possible for him to have more effective tools, we can all contribute to the improvement of service to disabled children and youth.

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Rehabilitation Center Planning

An Architectural Guide

By F. Cuthbert Salmon, AIA

and

Christine F. Salmon, AIA

Published by Pennsylvania State University Press, University Park, Pa. 1959. 164 p. illus., diag., architectural drawings. (With Supplement 1958. 26 p. architectural drawings.) $12.50

Reviewed by E. Todd Wheeler

The substance of this excellently detailed planning guide appears in Chapter 6, *Areas of Activity*. In that chapter of 117 pages (in a total of 164) are found valuable resource materials, particularly in the areas of physical and occupational therapy, speech and hearing, and vocational training. Separate but less extensive chapters on programming, planning, site, and environment and a bibliography complete the material. The functional approach is made to each section, though not uniformly. The detailed development of Chapter 6 is superior. Unit plans for each department are shown as illustration, but complete plans are reserved for a separate 26-page supplement illustrating 10 rehabilitation centers. The weaknesses and shortcomings are largely of form (poor correlation of text and drawings), though I also felt a lack of substance in the sections on program. An index would be helpful in a work that will be used as a detailed reference. In view of current interest in the subject, this guide is both timely and valuable and the authors are to be commended for their work in assembling planning data on rehabilitation centers.

In reviewing, I found myself being forced to overcome an initial and rather marked resistance to the slick format, and I hope my friends the Salmons will be charitable with me for this and other subjective responses to their magnum opus. Let it be said, in fairness and commendation, that they have packed into this volume much substance that did not appear in the draft of two years ago.

My first reaction was that the volume itself offered a good example of the unsolved problem of form and substance, a problem encountered by the thoughtful architect on every building he designs, but when I

About the Authors . . .

Mr. Salmon in February, 1959, was appointed professor and head of the School of Architecture and Applied Art, Oklahoma State University, Stillwater, moving from Pennsylvania State University, where he had been associate professor of architecture since 1948. He has been associated with architectural firms in Ottawa, Canada, Philadelphia, and Chicago. He received his bachelor's and master's degrees in architecture from the University of Pennsylvania. A native of Canada, he was a lieutenant commander in the Royal Canadian Navy during World War II. Mr. and Mrs. Salmon, both members of the American Institute of Architects, have specialized in the planning of rehabilitation facilities, having served as architectural consultants to the National Society for Crippled Children and Adults for many years. Their book, reviewed here, is a result of a research project sponsored by the Conference of Rehabilitation Centers and the AIA, under a grant from the U.S. Office of Vocational Rehabilitation.

About the Reviewer . . .

Mr. Wheeler is a fellow of the American Institute of Architects and a member of the American Hospital Association. For the past 18 years he has concentrated on the planning of hospitals, clinics, and medical schools throughout the United States, as architect and planning consultant. He has participated in numerous planning institutes of the AHA and the AIA and has published a number of articles on hospital planning. At present he is associated in the practice of architecture with Perkins & Will, of Chicago.

got into Chapter 6 this reaction began to fade. It was strong enough at the outset, however, to justify a gentle warning here that it will pay the reader who first reacts as I did to go on, as I had to, to benefit from the substance that is to be found.

The form of the book offended me, as do so many of our popular weekly picture magazines, by implying that ideas, to be considered, must be presented in capsule form: brief, curt, concise, and with lots of white space surrounding the gems of information and opinion. For some subjects this form may be excellent, but, for a reference text, I feel it tends to build weight but not value. The generalizations appearing in the first three chapters are not good enough or the diagrams significant enough to convey the ideas. Poetry is literary shorthand, but a short poem is no better than a long one unless it expresses ideas that cannot be better conveyed at length. I feel that in this book the attempt has been made, unnecessarily, to condense into a shorthand text what need only be presented in detail to be of obvious value. Somehow the shorthand does not come off, and the chapters dealing with program theory, planning principles, and environmental factors suffer from generalitis. They are neither artistic enough nor succinct enough to rise above the advertising form.

Yet the main part of the book needs no apology; in fact, it has my enthusiastic commendation. In it is to be found a quantity of information that is of solid substance, and, once we get past the obstructions of form, we find valuable and thought-provoking material, much of it new.

By far the best sections occur in Chapter 6, *Areas of Activity,* in the presentation of informative detail illustrating the functional planning principles. In this chapter numerous possible activities are analyzed and developed, both as to plan and function. Of special value to the planner is the method of approach used in each section, which presents a general description of what is done in the section, suggestions on the organization of space and of the essential internal relationships, and some material on the staff-to-patient ratios. Probably the best organizational diagram is the one for physical therapy (p. 47), but all sections have one of these.

It is in the detailed development of specific requirements that the worth of the textbook appears. Starting with the basic determinant of the patient in a wheelchair and the clearances necessary for him to maneuver (see Chapter 4), the text translates program elements into specific plans, showing furniture and equipment as well as building. Then follows description of the special equipment with illustrations in plan and perspective. The text gives comments on special relationships, details of construction and finishes, sound control, and patients' activities. Illustrations show clearances and dimensions. My own long-time crusade for having lavatories mounted at 36 inches, floor to rim, gains support by the requirement that the bottom of the lavatory be at 30 inches to clear a wheelchair armrest.

The authors have been careful to deal only with planning method and not with standard plans, thus providing the architect reader with the tools for planning but not the executed examples. They have also excluded items not specifically relating to the rehabilitation problem even though present in such buildings. As a result, there is a little of the feeling that they have never come to grips with the real problem of planning a rehabilitation center. This is probably inevitable in making the theoretical approach, but I wish they had used some of their extra white space to show and to comment on the plans that appear in the supplement, and, for that matter, to include other examples from the many rehabilitation centers they visited. Such plans published in whole or in part with illustrative critical comment would add a great deal to the presentation. I regret the fact that we architects generally refrain from critical comment both of our own work and of the work of others. I suppose we do this because of professional reciprocity or possibly for fear of a damage suit. It's a pity.

The supplement itself, issued separately and dated 1958, contains useful program information on each of the 10 projects illustrated in plans, but the tables *Disabilities Served* and *Referrals* give percentages of total not actual load, and the figures on annual caseload are not adequately defined. Hence, it is not possible to relate the number of patient treatments or patient visits to the size of each department. It is possible, however, to relate professional staff to the space provided. This is probably intentional, but I feel that in omitting actual performance figures the authors have excluded a potentially valuable planning guide.

A minor criticism of the presentations in Chapter 6 arises from lack of identifying notes and certain other essential information on the graphic material, *e.g.:*

a. The plan of the toilet room on page 45 would benefit from a reference to page 138, on which are detailed numerous devices to aid the patient in the use of toilets.

b. The diagram on page 47 could use some explanation of the graphic symbolism. And what does A.D.L. mean to an architect?

c. No room sizes are given on the plans. A few are dimensioned. Only about half the plans bear scales.

d. The plan on page 63 seems redundant.

e. Text and drawings sometimes get separated. It took a little figuring to relate the title *Occupational Therapy Treatment* on page 74 to the 2-page perspective on pages 76 and 77. The text refers to 16 stations. It would have helped to have had these numbered. Sometimes plan and perspective of the same room do not agree.

f. In many places the text describes sound principles of detailed planning but the drawings do not illustrate them. With illustrations as profuse as they are, this should not happen.

g. A number of the drawings have been reduced so in size that the essential dimensions cannot be read, though in general the graphic work is excellent.

h. I dislike the use of *and/or,* especially in a title (p. 90).

i. Page 103 needs a title and a little explanatory note to help us understand the blue arrow.

j. Since quite a point is made about the weight of hydrotherapy equipment and of certain shop machines, it would be helpful to have some of those weights shown, or perhaps ranges of weight. Also water and electrical loads might be shown.

k. I presume the blue lines on the bathroom plans on page 141 represent the minimum area for a 180-degree turn of a wheelchair, although it is not stated.

l. All of page 15 presents what would be given in one small table.

These are criticisms of form and not of substance. In considering a work of art they would be carping, but for a reference text they are justified.

Chapter 7, *Environmental Considerations,* is one many architects would like to see much more fully developed. The two-and-one-half pages of text are couched in general but informative terms. This chapter could well have been as fully detailed as the longer chapter on planning. This constitutes a real lack of substance.

A more important criticism, of substance not form, is of the general shortage of information relative to the size of each service. This is an area admittedly difficult to develop. The authors have included the following material at the beginning of each section in Chapter 6:

A. *Medical*
   1. *Physician*—Staff-patient ratio must be determined for each center separately according to services to be rendered.
   2. *Physical Therapy*—A table on visits per week, treatment hours, and the number of therapists. Some reference is made to the number of therapists working in various units.
   3. *Occupational Therapy*—Similar to the above.
   4. *Speech and Hearing*—Ranges of staff-patient ratios are given.
   5. *Orthetic and/or Prosthetic Appliance Shop*—A minimum facility is shown.

B. *Social Adjustment*—Ranges of staff-patient ratios are given.

C. *Vocational*
   1. *Vocational Evaluation*—Staff-patient ratios are given. Minimum size of 1,000 square feet is given.
   2. *Vocational Training*—Size will vary.
   3. *Sheltered Workshop*—Size will vary.

D. *Inpatients*—No staff-patient ratios. Size of units varies.

E. *Children's Treatment and Training*—Ranges of staff-patient ratios are given.

F. *Administration*—Size varies.

G. *General Areas*—Size varies.

From this information and application of the planning principles, the architect should be able to design the component parts of the center and then put them together. Yet the section on program does not guide him in the elementary but most difficult area of translating estimated need into physical facilities. Perhaps this problem is thought to be outside the province of a planning guide, but it is a problem that must be met in every project. Just how large should each section be? Too often this is established by default, or by budget limitations, or by guessing, all to the later regrets of those who operate the building.

Chapter 3, *Rehabilitation Center Programming,* touches on this problem generally and qualitatively, but the quantitative guides are lacking. Tables given subdivide disabilities and referrals into percent of total but do not indicate probable ranges of loads. Chapter 2, *Rehabilitation and the Community,* fails to cover this. We cannot consult this guide to find out how large a rehabilitation unit should be to serve a population of 100,000 or of 10,000. True, there are no known formulas to establish the proper size, but I feel that some specific perspective on this would be a helpful guide, such as analysis of floor area by departments of selected centers. At one point (p. 105) it is stated that 1,000 square feet is considered minimum for a vocational evaluation unit, but no such figures are given for other services. Perhaps a review of the about 50 references given in the bibliography would reveal material to fill this gap.

Chapter 4, *Planning Principles,* makes an excellent approach. The best thing in it is the emphasis on planning for wheelchair operation clearances (p. 20 to 25). This is an obvious need, but few of us would even comprehend the problem without research, and the information given here provides the necessary background data. Some of the generalizations in this chapter seem obscure or redundant, for example, that on modular flexibility, p. 30.

Chapter 5, *Site Considerations,* leaves much to be desired. However, this is a subject well known to architects and perhaps what is given is sufficient. Some of the conclusions on budget seem to call for explanation.

I found only two errors, both minor, although I am sure there are others.

On page 71 the titles for the bicycle jig saw and treadle sander were reversed.

On page 158, third column, the title *Plumbing* and the first two lines of text should be at the bottom of the column to carry over to the succeeding page.

In this review I have, like many a critic, dwelt upon deficiencies and difficulties more than upon true merit. The merit of this book lies in the great quantity of useful information, contained principally in Chapter 6 and representing two-thirds of the volume. For that alone it is well worth having and using as a planning guide.

Other Books Reviewed

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And Everything Nice; A Parents' Guide to Bringing Up Daughters

By: **Vance Hyde**

1959. 240 p. David McKay Co., 119 W. 40th St., New York 18, N.Y. $3.95.

MOTHERS AND FATHERS of young daughters should find Mrs. Hyde's practical advice, spiced with amusing comments on her own trial-and-error methods, most helpful in the rearing of girls from babyhood through the trials of adolescence. Here is a mother who enjoyed and planned carefully the growing-up process of her three daughters. She learned how to instill in them the pleasure to be derived from shared housework, the need for personal grooming and appreciation of beauty in appropriate dress, the practical management of money, and the value of an educated mind and heart. Chapter 11 discusses special problems parents must meet in helping a handicapped little girl to live as normal a life as possible.

881

Beschäftigungstherapie Einführung und Grundlagen

Edited by: **G. Jentschura**

1959. 299 p. illus. Published by George Thieme Verlag, Stuttgart, Germany, and available in the United States and Canada from Intercontinental Medical Book Corp., 381 Fourth Ave., New York 16, N.Y. Price: DM 45 ($10.70).

THIS TEXTBOOK of occupational therapy describes handcrafts and the application of occupational therapy technics in the treatment of disability, such as orthopedic conditions, poliomyelitis, arthritis, cerebral palsy, those of traumatic origin, and amputations. Sections are also included on occupational therapy technics for functional training, for use with patients with tuberculosis, and for management of the psychiatric patient. Well illustrated, it also contains a five-page bibliography of the literature and a subject index. Text is in German.

882

Hearing with Our Eyes, Book II: A Lipreading Textbook with Manual for Accompanying Workbooks for Teachers of the Deaf and Hard of Hearing

By: **Ena G. Macnutt**

1959. 198 p. Paperbound. (Together with: *Lipreading workbook to accompany Hearing with Our Eyes, Book II.* 30 p. Paperbound.) Alexander Graham Bell Assn. for the Deaf, 1537 35th St., N.W., Washington 7, D.C. Textbook-manual, $4.70; accompanying workbook, 65¢.

BOOK II contains a series of 27 lipreading lessons, each consisting of 32 sentences, a story or informative material, and two drill devices, for use with junior or senior high school pupils beginning lipreading. Format follows the same general plan as that found in *Hearing with Our Eyes, Book I* (see *Bul. Current Lit.*, Mar., 1953, #261), prepared for use with elementary school pupils. The material in both books was used for years in the public schools of Newton, Mass. The introduction explains in detail methods to be used in presenting the lessons both for lipreading practice and for learning to listen. The accompanying workbook affords both the pupil and teacher a check on progress made; it can be an incentive to learning for the pupil.

883

I Had a Little Nut Tree; A Reconstruction of Childhood

By: **Louis Battye**

1959. 261 p. Martin Secker & Warburg Ltd., 7 John St., Bloomsbury, London, W.C. 1, England. 18s, net.

UNLIKE MANY autobiographies of disabled persons, this account of the author's childhood until the age of 16 is not primarily concerned with his handicap. Louis Battye writes charmingly and with humor of his early life in a Yorkshire valley in England. Born of working parents during the early 1920's, he experienced the ups and downs of the family's lot during the economic depression following World War I. Having spastic cerebral palsy since birth, he was deprived of activities other boys enjoy but it apparently did not lessen his enjoyment of the people, places, and experiences of his life. Mr. Battye has never walked and has only limited use of his hands and arms—in the bodily sense he is almost helpless. None of this is reflected in his book; he has been too busy enjoying life to have time for self-pity.

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I Reclaimed My Child; The Story of a Family into Which a Retarded Child Was Born

By: **Lucille Stout**

1959. 89 p. Chilton Co., Book Division, 56th and Chestnut Sts., Philadelphia 39, Pa. $2.75.

ON THE ADVICE of several physicians and a nurse who urged institutionalization of their baby daughter, a mongoloid, Lucille and Lafe Stout applied for her admittance to a state institution at 11 months of age. Mrs. Stout tells of their stunned disbelief at the diagnosis and their struggle to accept the fact and overcome self-pity. The child in the institution was not forgotten however; the family found the strength and understanding to "reclaim" Carol. Although still institutionalized, she comes home for holidays and summer visits, is accepted by the community, and has become a part of their family life. The book presents a moving account of the emotional impact of retardation on one such family.

885

A Manual on Terminology and Classification in Mental Retardation

By: **Rick Heber**

1959. 111 p. tabs. Paperbound. *(Monograph suppl. to Am. J. Mental Deficiency. Sept., 1959. 64:2)* Published by and available from American Association on Mental Deficiency, P.O. Box 96, Willimantic, Conn. $2.00.

PUBLISHED IN preliminary form as a supplement to the *American Journal of Mental Deficiency,* this manual should help clarify terminology as applied to mental retardation and all its aspects. Members of the Association are asked to make suggestions and recommendations before the material appears in final form in July, 1960. Five major sections cover definition, medical classification, behavioral classification, statistical reporting, and a glossary of terms most used in the field. Both the simplified and expanded versions of the medical classification scheme are presented, with definitions for each category. An illustration of a statistical record system that might be used in a public residential center for the mentally retarded is given; it is useful as a guide to the type of data required by state authorities, for national reporting, and for meeting special needs or interests of the institutional staff. The record system is designed for IBM equipment. It incorporates the proposed medical and behavioral classifications. Terms defined in the glossary are interpreted so they can be understood by personnel in other disciplines working with the retarded. The manual is the fifth of a series of such manuals published by the Association since 1921.

886

Planning Homes for the Aged

Edited by: **Geneva Mathiasen** and **Edward H. Noakes**

1959. 119 p. architectural drawings. F. W. Dodge Corp., 119 W. 40th St., New York 18, N.Y. $12.75.

THIS FIRST practical and comprehensive guide to the planning of homes for the aged and the chronically ill contains 11 chapters contributed by authorities in the fields of architecture and welfare of the aged and ill. Discussed are congregate living for older people, community needs and resources, location and building site, planning of specific parts of a home, function of the architect, and details of construction (materials and costs). Section II presents top winning designs from an architectural competition conducted by the National Committee on the Aging jointly with *Modern Hospital* and *Architectural Record* magazines. The book should be of very practical value to those involved in the planning, construction, and administration of such facilities.

887

Psychology and Rehabilitation; The Proceedings of an Institute on the Roles of Psychology and Psychologists in Rehabilitation . . . Princeton, N.J., February 3-7, 1958.

Edited by: **Beatrice A. Wright,** Ph.D.

1959. 146 p. tabs. American Psychological Association, Dept. PAR, 1333 16th St., N.W., Washington 6, D.C. $1.50.

FUNCTIONS AND responsibilities of psychologists in rehabilitation have been studied by special committees of the American Psychological Association since 1955. On the recommendation of the Education and Training Board Task Committee, the Institute was planned to clarify contributions psychologists could make in rehabilitation. Subjects discussed were the scope and nature of rehabilitation, place of psychology in programs, professional training for rehabilitation work, interprofessional relationships (based on results of a survey of members of various professions engaged in rehabilitation services), research as a function of psychologists, and specific areas needing investigation. Two sessions of the Institute were devoted to invited addresses: "Rehabilitation Today and Tomorrow," by Mary E. Switzer, and "Next Steps in Rehabilitation," by Howard A. Rusk, M.D.

Additional helpful materials included are a 12-page bibliography, a section suggesting research topics, a subject index, and a list of Institute participants. The Institute, originally intended to consider only the psychological rehabilitation of persons with physical disability, was enlarged in scope to cover emotional and mental disabilities.

Journal articles, chapters of books, research reports, and other current publications have been selected for digest in this section because of their significance and possible interest to readers in the various professional disciplines. Authors' and publishers' addresses are given when available for the convenience of the reader should he desire to obtain the complete article or publication. The editor will be most receptive to suggestions as to new publications warranting this special attention in Digests of the Month.

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Lower Extremity Braces in Rehabilitation

By: **Michael M. Dacso, M.D.** *(New York University-Bellevue Medical Center, New York 16, N.Y.)*

In: *G.P.* October, 1959. 20:4:102-109. (Illustrated)

Although general practitioners are increasingly called upon for restorative medicine, very few have had the time and opportunity to learn about the considerable technical problems involved in management of the disabled. Thus this article on basic principles of bracing may help many physicians anxious to fill in a gap in their knowledge on this subject.

It is essential that the physician recognize that the prescription of orthetic devices is his exclusive responsibility and should not be relegated to the bracemaker. (The new term *orthetic* designates a medically prescribed device applied to or around a weakened body segment to give support and increased function.) Bracemakers do not have the prerequisite of detailed clinical information. The physician must establish the indications, write a prescription, check the adequacy of the appliance after delivery, and refer the patient to an appropriate place for training.

Criteria for prescribing as outlined by Bennett include the requirements that the device must: serve a real need; be designed so any good orthotist can construct and repair it; be light but sturdy enough; be reasonable in cost; be simple enough for the patient or his family to apply; be acceptable in appearance; and in no way endanger the structural security of body segments through its use.

Elements of a brace for the lower extremity usually are metal uprights, joints, bands, locks, and a number of mechanical refinements as indicated by the patient's needs. There are usually two parallel uprights. Short leg braces end below the knee at the level of the internal condyle; long braces end about one-half to one inch below the ischial tuberosity. In short leg braces sometimes only one upright is used, placed laterally or posteriorly. For growing children, there are specially constructed adjustable uprights.

Braces are made of solid or tubular steel or aluminum. Steel, though heavier, is used when increased strength is desired; otherwise, aluminum is preferred. Steel wire uprights have been employed for small children or elderly women where unusual strains and stresses are not expected, since the wire is lightweight but fragile. Except when there are foot-plates, the brace is attached to the shoe, which becomes an integral part of the appliance.

Lower extremity braces are used mainly to prevent and correct deformities and sometimes to eliminate weight bearing. Except when braces have an ischial ring, the body's weight is supported indirectly through stabilization of the joints.

Joint types used mainly in the ankle region are the caliper and the stirrup. The simple and inexpensive caliper type is functionally unphysiologic, being fastened directly to the shoe sole, with a functionally undesirable discrepancy between the anatomic and mechanical joints. A caliper is acceptable for small children, as the ankle joint is closer to the sole and prolonged ambulation is not expected. The stirrup joint assures free motion as it has moving parts that coincide with the anatomic ankle joint. It is preferred. Both joints may be manufactured for easy transfer from shoe to shoe.

Long leg braces correct disabilities in or above the knee. The brace's knee joint should be at the level of the femoral condyle, about one inch above the joint space. No knee joint as yet is entirely satisfactory due to the complex polyaxial movements of the human knee. Persons not experienced in the finer details of bracing should not prescribe the more complicated polyaxial mechanical joints. The basic joint structures are the lap and box (costlier) joints.

Braces including the hip are used mainly for stabilization of the hip joint or elimination of weight bearing. For stabilization, modifications of pelvic bands are used. For weight bearing, an appropriately designed ring or bandlike structure is used that allows the ischial tuberosity to sit on top the brace. This device, called the ischial weight-bearing brace, short-circuits the injured or diseased hip and transfers the body weight from the skeletal system to the foot.

When a pelvic band or a higher attachment such as Knight's spinal extension is used, the hip joint mechanism

must coincide with the greater trochanter. Prescription of a spinal extension directly attached to a long leg brace is more complicated and should be tackled only by the more experienced.

Locks are used with free-moving joints when muscles have lost their ability to stabilize the anatomic joints in weight-bearing position. The ring lock, mechanically the simplest, is a precision-machined, collarlike structure. Because of gravity it drops around the brace joint and demobilizes it when the patient stands. It opens with a simple manual procedure. More complicated locks have advantages but are more apt to fail or get out of order. The lock on the knee should be attached as a rule to the lateral joint, but for hemiplegics it is placed over the inside joint for easier access by the unaffected hand.

Cuffs are leather-covered metal bands that add to the support of the limb and to the sturdiness of the brace and facilitate application of the brace. Cuffs must be properly measured and fitted to the contours of the limb, so that they are not painful and do not throw the brace off balance, decreasing its corrective value.

Pelvic bands, attached to the brace in the hip region carefully following the contours of the pelvis, are used to stabilize the hip joint, prevent or control external or internal rotation, adduction, and abduction. Even the best constructed interfere with muscle and joint function; they should be used only when control of pathologic movements is really needed.

Regulating range of joint motion is done when needed, as in foot drop in some hemiplegics or in poliomyelitis or peripheral nerve lesion. Here a 90-degree stop is applied at the ankle joint. The Pope-Klenzak joint, which uses a spring mechanism to regulate joint motion is popular but in spastic conditions may precipitate ankle clonus. Other devices limit the excursion of hip or knee joints.

Brace accessories may improve the corrective value of a brace. Some used in simple braces are discussed below.

Ankle straps are T-shaped, padded, wide leather bands attached directly to the shoe that pull the ankle closer to the opposite upright. Depending on whether it is attached to the lateral or medial aspect of the shoe, the strap will correct varus or valgus deformity of the ankle. In correction when pressure is created in the knee or ankle area, pressure pads can prevent damage to the soft tissue. These are simple metal discs or rings padded with leather, felt, or foam rubber. Kneecaps are prescribed when muscle weakness or complete paralysis has impaired the stability of the knee. They aid in re-establishing axial alignment in a mild flexion contracture.

Measurement and final fitting should be done in either the physician's office or the hospital rather than in the bracemaker's shop, with the physician present. The patient will be better satisfied if he recognizes the physician's importance in prescribing and his supervision of the manufacture, fitting, and training. In rural situations, the physician must often learn the procedure of brace measurement and be familiar with minor alterations often needed.

In measuring, the patient lies down so that a sheet of heavy wrapping paper fastened to a hard surface is under the extremity, which is then traced. The paper must have enough space for notes and markings. In case of flexion or other deformity, a lateral view must also be recorded. Circumferences are measured with a cloth tape measure and indicated on the tracing in the following levels: (1) trochanter to perineum, (2) thigh at perineum, (3) mid-thigh, (4) lower thigh, (5) femoral condyle, (6) knee joint line. (7) tibial condyle, (8) calf (maximum), (9) lower leg, (10) above ankle (minimum), and (11) ankle at malleoli. Longitudinal measurements extend from: (1) trochanter major to sole, (2) ischial tuberosity to sole, (3) knee line to sole, and (4) ankle to sole. Measurements and instructions are written on the tracing.

The final check-out of the brace must be done with the patient actually wearing the brace. The physician must check thoroughly for proper placement of joints and bands and see that the uprights, especially in the joint areas, are about one-half inch from the extremity. Binding by cuffs or pressure by upright invariably indicates malalignment and should never be corrected by padding of pressure areas. The leatherwork must be smooth and free of unfinished edges. Locks must close precisely and promptly.

The use of bending irons (for making minimal changes in the uprights) requires considerable skill. Binding, popping rivets, and rubbing joints on uprights are usually signs of gross malalignment and should be corrected by careful realignment rather than by tampering with bending irons.

Training in using the brace must be given for the patient to obtain full benefit from his braces. First, applying and removing braces must be carefully demonstrated and practiced with the physician present. If possible, a qualified therapist should train the patient in using the brace under the physician's supervision.

Maintenance is needed to keep the brace in good working order. Moving parts should be sparsely oiled biweekly (a thin layer of petrolatum is preferred on removable moving parts). A clean rag is needed for simple care of uprights and leather cuffs and a screwdriver is used for minor tightenings. Major repairs should always be made by a bracemaker. An especially careful maintenance program is advisable in spastic and hyperkinetic patients where the mechanical strains and stresses tend to shorten the life expectancy of the brace.

With the information furnished here and with continued studies and practical experience, it should not be difficult for practitioners to learn to prescribe simple braces. Where ever possible the physician should spend a few hours in a bracemaker's shop. Firsthand experience in the manufacturing process will help him to understand the technical aspects of bracing.

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Experiential Programming for the Cerebral Palsy Child

By: **Harold Michal-Smith,** Ph.D. *(Chief Psychologist, Flower and Fifth Avenue Hospitals, 1 E. 105th St., New York 29, N.Y.)*

In: *Education of Children with Cerebral Palsy, Workshop Summary, p. 2-10.* Sponsored by the Bureau for Handicapped Children in cooperation with United Cerebral Palsy Association of New York State and New York Institute for the Education of the Blind and held March 19-21, 1959. Var. paging. Mimeo. Albany, New York State Education Dept., 1959. (See #905, this issue of *Rehab. Lit.*)

The problems of cerebral palsy are complex and difficult, particularly from an educational point of view. Since only long-range experience can validate or invalidate, I have termed our approach to the programming for the cerebral palsied "experiential"—it develops from the lived, the actual, the experienced, arising from the positive dynamics of the teacher-child relationship.

Realistic Educational Goals

We cannot let our own needs or wishes for achievement overshadow the reality of the child. Contact with the *individual* child must be the basis of planning; without contact, goals are "theoretical." Over-all we do need theoretical goals for administrative planning of curricula and all long-range planning. We must distinguish theoretical and realistic goals in their essence for valid application to a given situation.

Our theoretical goal is to give all children in our care maximum support and understanding, whether the individual child meets our individual expectations or not. Our theoretical goal also is to encourage all to use their capabilities toward maximum exploration and understanding of the actual, immediate environment and toward maximum self-maintenance. Within the framework of a conceptual goal of maximum exploration, our realistic goals must be the study and development of technics to stimulate curiosity and interest in the environment; to overcome passivity; to reduce immobilization created by the physical handicaps and consequent frustrations, anxiety, and sense of defeat. Within the theoretical goal of understanding is the realistic goal of awakening and stimulating the available intelligence of the child. This realistic goal calls for the further development of testing and teaching technics, of evaluations of available intelligence, and of specific aims for the individual child.

Within the theoretical goal of self-maintenance, the immediate goal may be as primitive as toilet training, the long-range as bold as economic independence. The realistic goals are vocational training, job training, job hunting and job finding, and teaching the individual to live as an adult in our economic world.

Goals for the Severely Handicapped

Experience in the art of living in this world as we know it is not truly possible for some of our cerebral palsied children; at best the school may be able to supply a substitute experience, based on the realistic limitations and/or potentials of the child. Whatever specific restriction, there is usually as well a deficit in total personality development, function, and behavior. The entire Gestalt, the entire "way of being and acting," is affected and manifests itself in severe misapperception—distortion of reality. In setting realistic goals for these children, we must take into account the difficulties, obstacles to accurate perception of and appropriate reaction to his environment, and serious limitations to the synthesis of experiences that do reach him. It becomes a question of creating the experiences for him and also of gauging how much he can use or gain satisfaction and growth from. The individual child rather than the group is evaluated; realistic goals here may include the frequently unmentionable word institutionalization. Placement outside the home may be the most practical and most satisfying plan for some, due to the nature of severity of the multiple handicap, to mental and emotional limitations, or to problems in the family constellation.

Rehabilitation in its largest sense does not necessarily mean adjustment or absorption into community life; it means satisfactory adjustment within the framework of the disability. A child forced daily to meet demands he cannot fulfill is not being rehabilitated; his already imperilled feelings of minimal adequacy or security are being destroyed. To him living in a safe, protected, accepting atmosphere with others on his own level is more satisfying than remaining a lonely, rejected, and bewildered outcast. For some the institution may be only a temporary refuge, for others a half-way house, and for others a permanent, secure, and happy home.

Admission Standards for School Programs

Realistic educational goals must involve certain limitations and determinations to school admissions. An ideal

method of admitting would have a one-year trial and evaluation period, with the child exposed to all available therapies and educational and social stimulation and then evaluated in the multidiscipline approach, involving the total team of professionals. If progress is seen, further investment of time, money, and effort must be recommended; the child should be accepted for long-range educational planning. If progress is not made, parent groups should arrange for day care centers or other forms of custodial attention.

The observation period would fill in the gaps of our knowledge of a specific child. It would save the child who might have been turned away prematurely and remove one who would not profit from the school program even though initial indications were good.

The maintenance of functional admission standards, regardless of parental pressures, prevents futile investments of relatively scarce professional and educational services and protects that investment for the children who can benefit. Indiscriminate admission does not help incapable children but may be detrimental. Admission standards must be realistically set in view of the general handicaps of the major city of the cerebral palsied population.

Special Consideration for the Cerebral Palsied Adolescent

Because of the relatively slow learning rate of the cerebral palsied, it might be important to consider starting vocational training at an earlier age and stepping up training for independence. Often the necessarily overlong period of childhood dependence has perpetuated in varying degree the immaturity of the cerebral palsied individual. The school must supplement or even substitute for those forces normally inherent in adolescents. The vocational counselor, the psychologist, teacher, and administrator must work as a team to see if the child can fit into the economic community and decide what training area would most benefit the child in terms of community opportunities that are available and according to the child's own capacities.

Vocational and workshop planning must recognize the increasing mechanization of industrial process, which has absorbed a greater amount of semiskilled labor. A more thorough public relations program is indicated to enlarge job opportunities for the less limited cerebral palsied persons capable of more advanced skills, who *can* find a place. But what about the semiskilled and their need to work usefully and be recognized by others? Important here is the sheltered workshop, the kind of work and the gratification offered, and the social usefulness of the projects. The community must be educated for acceptance of skilled cerebral palsied persons; it must also provide for those not completely self-sustaining but who do not need custodial care. These problems should be considered during a child's adolescent period, where long-range planning can be most effective.

Psychological Aspects

Psychological handicaps can be a profound factor in the development of a child. Because of physical disabilities and ensuing frustrations, psychological disturbances may well be more profound in a cerebral palsied child. Psychological evaluation is a prerequisite for the assessment of capacities and provides a realistic basis for programming. Attitudes are a primary factor in the will to do, win, accomplish, and cooperate. How the child expects life to treat him is part of how he will respond to education and therapy. We must know not only what the child *has* but what he is apt to *do* with what he has.

Possibly the greatest factor in shaping the prognosis and the program is evaluation of intellectual endowment. Much literature gives the impression that valid testing of intelligence is impossible due to patterns of behavior in the cerebral palsied child. I believe that competent psychological testing taking all factors into consideration can be a valid frame of reference. It is not a question of pigeoning him into an I.Q. level but of placing him on a comparative basis within the wide scope of accepted, normative ranges of mental development. Our very human susceptibility to disabilities must not affect our clinical evaluation. Mental retardation is very common in these children and must be faced. We will serve the child best by adhering to clinically established fact, by learning to know him as he is, by training him toward what he best can be. By attempting to make a child reach for what he cannot grasp, we may hamper learning.

Emotional Problems

Emotional problems exist in the disabled child, his parents, and in teachers and therapists. In our society even the normal person is acutely anxious lest he differ from his neighbor; the handicapped is at a grievous disadvantage and must manifest a proliferation of emotional problems. The cerebral palsied is also an emotional problem to others. Many feelings other than love enter the relationship between parent and child. Besides beloved object, the child is the object of parental ego drives, as an unconscious extension and perpetuation of the parental ego rather than an ego or personality in his own right. Also, over the past 20 years psychological pressures on the parents as the source of all emotional disturbance in the child have increased with concomitant overreactions of guilt. Personal suffering is communicated unconsciously to others, of course to the child, with the inevitable dynamic of reaction and counteraction of ensuing tensions.

The teacher also has a need for a sense of accomplishment, of pride in results. This, in a form more diluted than that of parents, is in all of us who work with children. The possibility of countertransferences in terms

of ego identification also exists. Teachers may have stronger needs for accomplishment than can be met by the handicapped child and may experience unwarranted frustration and fatigue. Their disappointments may in turn affect the child, who, as at home, will find himself again inadequate to the expectations of the adult.

Conclusions

Precisely because I feel that a form of dedication is involved in teaching and therapy with the cerebral palsied child, I feel the child's best interests are served when the teacher maintains a realistic understanding of the child's abilities, neither underrating him because of her own disappointments in his progress nor overrating him because of her own hopes for accomplishment. The child flourishes best in an atmosphere and under a tutelage that permits him to do his best by offering motivation, opportunity, materials, contact, and acceptance. The teacher explores her own technics and experiences without fearing failure, but with the realization that success is not necessarily inevitable. It is far better to have a wholesome respect for the problems and obstacles en route than to pretend they do not exist or to minimize them. Our strength lies both in our conceptual vision and in the daily close-sightedness we bring to our work. Success in the education of the cerebral palsied child lies not only in the outcome but in the *very effort* that the child and teacher make to achieve it.

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Rehabilitation of Beggars in Bombay State

By: **S. D. Gokhale** *(Superintendent, Beggars Receiving Centre for Males and Females, Bombay, India)*

In: *Indian J. Soc. Work.* March, 1959. 19:4:325-330.

Begging is a blatent manifestation of ethical deterioration and personality disorder that compels a man to shed his self-respect and transforms him into a being devoid of human dignity. This problem is typically urban and is vast. Since it has its roots in the socioeconomic fields, it cannot be solved easily.

Those who usually land on the footpaths of Bombay are in need of relief or rehabilitation. One group consists of persons suffering from diseases and unable to find employment. They are casual beggars, not professional. The second group are professionals who desire to make quick money and depend on others' charity. In India, it is not possible to solve this problem through legislation. A helping hand can be extended to the needy, handicapped, and diseased driven to begging, and the professionals can be processed through advanced techniques of correctional welfare.

Law.—The earliest law on begging in modern India was the European Vagrancy Act of 1874. The Bombay Beggars Act was passed in 1945. The Act is reformative but also penal so far as exploitation or contumacious vagrancy is concerned. In 1946, it was applied to the town and island of Bombay, certain parts of Thana District, and to the Railway line up to Virar and to Kalyan. In 1947-48, there were 923 persons taken charge of; in 1957-58, there were 3,013 apprehensions. About 5,500 were taken charge of in 1959-60 [*sic*]. In 1947-48, 497 persons were detained as against 1,211 in 1957-58 and 3,000 in 1958-59. In human welfare mere statistics cannot measure success or failure, but it can definitely be treated as indicative.

The Bombay Beggars Act provides for commitment to a Beggar's Home for from one to three years for the first offence and three to seven for subsequent appearances. It also provides for indefinite detention, which is used for deserving cases. Separate procedures are used for children and those suffering from leprosy or lunacy. Provision is needed for probation, case work, aftercare, and follow-up.

The cooperation of other states is needed, as a large share come to Bombay from other regions and Bombay cannot handle the problem single-handed. The Census Report of 1951 showed about 2,884 beggars in the city alone, but a recent survey showed about 15,000 in Greater Bombay.

Charity Indiscriminate.—The city of Bombay is very attractive and very paying so far as beggars are concerned. A Government report says, "The community in Bombay spends about Rs. 10,000.00 a day on beggars. This Bombay city is giving in cash at least 36 lakhs of Rupees every year to the beggars." In spite of this huge amount, a beggar remains a beggar. Every citizen is responsible for the existence of beggars on the streets by throwing large sums of money by way of indiscriminate charity, which is a criminal waste, as it only satisfies the urge but does not solve the problem. If this amount is canalised, a wonderful scheme of institutional and preventive programme can be developed.

Slowly this is being realised and voluntary and private agencies are coming to help the Government. Some of these are the Bombay Corporation, the Nagpur Corporation, and committees under the Mayor of Bombay and the Governor.

Plan Provision.—The Government proposes to develop care and aftercare programmes at Ghaitpatwadi and Visapur. These centres will be developed so that better ways of employment would be found for settling the beggars in agriculture side by side with cottage industries and small crafts. The Poor Home in Nagpur will introduce crafts with a view to unfolding hidden talents and creating a sense of honest, hard work. Similar projects are in view.

To make the scheme a success the whole community

must cooperate with the Government. It must not like begging. To lose one's self-respect is itself a great traumatic experience, and then the behaviour of the beggar is bound to deviate from the given rules of conduct. Let the community save our brethren from this profession of shame and assimilate them as useful citizens.

Causation and Typology.—The causes of begging are: 1) poverty and unemployment; 2) physical handicaps like old age and infirmity; 3) mental handicaps and personality disorders; 4) leprosy and tuberculosis; 5) broken homes and family discord; 6) desertion or destitution; 7) wanderlust; 8) religious reasons; 9) desire to cover crime by begging; and 10) greed for easy money.

Institutions.—Institutions symbolise the desire of the community to help the needy. The purpose of the Institution is to enable the person to come out of his undesirable past, reassemble the surviving forces of his personality, and equip himself with new skills so that he may ultimately be assimilated in society.

In 1945, there was one of each of the following: clearing house (now known as Receiving Centre); female beggars home, in Chembur; male beggars home, in Visapur; infirmary; home for the disabled; leprosy hospital; and home for the blind. Four mental hospitals were certified to receive beggars suffering from lunacy. The number of Institutions has shot up from seven in 1947 to 25 in 1959. The capacity of 1,500 has gone up to 5,000. The budget of Rs. 4,66,893 has risen to Rs. 1,30,000 in 1957-58. The Institutions mainly consist of: Classification Centre; Treatment Home; and Infirmaries and Asylums.

Procedure.—The Receiving Centre stresses classification and has five Probation Officers who go into the background of the beggars, find out the causative factors, and propose a plan of treatment. Case work technique is largely used in this programme. A psychological clinic is being built up.

In 1957 it was decided by the Hon. Minister that the beggars should be taken charge of according to the following priority: 1) beggars with leprosy; 2) physically handicapped and disabled; 3) aged, infirm, and handicapped; and 4) the able bodied. Three drives had been completed at the time of writing. The work done according to priorities is very effective and fruitful. Is it not the basic responsibility of the community to help those who need it most?

The scheme can look after only one-fifth of the beggar population. It cannot be said the Government cannot cope with it at once. But the process of migration and polarisation brings in more and more persons to Bombay, which is supposed to be the Solomon's Mines for the begging population.

Persons Taken Charge of from the First Drive (21-10-1957) up to Launching of the Fourth Drive (28-2-1959)

Group	Males	Females	Total
Able Bodied	2,212	488	2,700
Old and Infirm	1,294	519	1,823
Blind	326	39	355
Deaf and Dumb	85	11	96
Crippled	506	35	541
Tubercular	58	—	58
Mentally Handicapped	123	74	197
Lepers	850	135	985
Total	5,454	1,301	6,755

Projects.—Special homes teaching crafts are being developed or expanded. Organisation of workshops and work camps is being considered to see if good work habits can be inculcated into repeaters, although comparatively their numbers are not high. A modest experiment at Junagadh in which inmates worked for pay with no custodial supervision was successful.

The homes teach: tailoring and button making; gardening, agriculture, and poultry-raising; spinning; clay modeling; laundry; knitting; weaving; carpentry; canework; broom and coir work; leatherwork; bamboowork; oil pressing; chalk-stick making; music; braille; soapmaking. Small crafts such as dollmaking and bookbinding are encouraged. It will not be correct to think that a man trained in bookbinding will become a bookbinder after release. Actually he comes as a pathological case, and we should be content if work habits are inculcated in him and he is given a joy and excitement of creative activity.

In 1955-56, the Chembur Home, Worli Home, and Visapur Home fetched revenue to the tune of Rs. 56,000.00. To develop the case programme, the Government has bought 450 acres for sisal fibre cultivation and 325 acres of land for agriculture. More than Rs. 10,000.00 have been credited to the Government through employing beggars on outside jobs. Inmates have been able to purchase savings certificates and make small savings.

Help Needed.—If the community insists on indulging in indiscriminate charity, the beggars will still be on the streets, unkempt, hungry, diseased, at the doorsteps of death. With such a complex problem, no one can claim to do away with this evil in a short time. Members of society must pledge themselves and firmly work to do away with it in a given period. It may require planned work, great effort, and community enlightenment.

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This abstracting section, together with other numbered references indexed in this issue, serves as a supplement to the reference book Rehabilitation Literature 1950-1955, *compiled by Graham and Mullen and published in 1956 by the Blakiston Division of McGraw-Hill Book Company, New York. An author index will be found on the last page of the issue.*

AMPUTATION—EQUIPMENT—RESEARCH

891. California. University. Biomechanics Laboratory *(463 U.C. Hospital Bldg., 3rd and Parnassus Aves., San Francisco 22, Calif.)*

Summary report of proceedings, First Amputee Research Conference, University of California Medical Center, San Francisco, December 2-4, 1958. San Francisco, The Laboratory, 1959.

Contents: Development and organization of the Biomechanics Laboratory, Verne T. Inman.—The nature of the sensory apparatus in joint and periosteal tissue, Malcolm R. Miller.—Some possible neurophysiological mechanisms involved in pain perception, Louis B. Thomas.—Technical aspects of amputation surgery, Verne T. Inman.—Psychological aspects of lower-limb amputation, Henry F. Albronda.—The measurement of energy expenditure in human subjects, Henry J. Ralston.—Skin disorders of the lower-extremity amputee, S. William Levy and Gilbert H. Barnes.—Biomechanics of below-knee prosthetics, C. W. Radcliffe.—Purposes and results of the Richmond Institute, Warren E. Griffith.—Present status of orthetics at Warm Springs Foundation, Robert L. Bennett.—Proposals for research in bracing, Sidney Fishman.—Recent developments in bracing at Rancho Los Amigos, Jacquelin Perry.—The research and development program for upper-extremity orthetics, James W. Rae, Jr.—Outline of a pilot study in brace research, Verne T. Inman.—Review of upper-extremity research and possible direction of future research, Fred Leonard.—Overview of known sensory and motor resources available for prosthetic control, Hilde Groth.—Evaluation of control problems in externally powered prostheses, John Lyman.—Pneumatic controls for prosthetic devices, Raymond D. Atchley.—Proposed research outline for practical application of external power, John Lyman.

Participants were physicians and scientists engaged in medical research on amputee problems and engineers working on the design of prostheses. The medical and prosthetic aspects of both upper and lower-extremity amputation were discussed.

892. California. University. Department of Engineering

A functional evaluation of several surgical techniques for establishing prosthetic control sites, by Hilde Groth and John Lyman. Los Angeles, The University, 1959. 20 p. fig., tab. *(Biotechnology laboratory technical rep. no. 2; Rep. no. 59-35, June, 1959)*

A report of research conducted as part of the Engineering Arm Prosthesis Research Project at the University of California. Surgical technics reviewed as possible methods for establishing more satisfactory prosthetic control sites are: 1) muscle, tendon, and fascia relocations, 2) nerve relocations, and 3) cartilage implants. The investigators reviewed the literature pertinent to each of the three areas to seek clarification of problems related to control site criteria and the time interval elapsing between surgery and recovery of function. They believe that nerve crossing seems to offer the most fruitful initial approach, even though the time interval between surgery and functional recovery is relatively long. Psychologically, the technic appears the best solution since activation of the control site will be associated with a previously meaningful action. Bibliography of 44 references. Issued by the Dept. of Engineering, 3116 Engineering Bldg., University of California, Los Angeles 24, Calif.

AMPUTATION (CONGENITAL)—MEDICAL TREATMENT

893. Aitken, George T. *(50 College Ave., S.E., Grand Rapids 3, Mich.)*

Amputation as a treatment for certain lower-extremity congenital abnormalities. *J. Bone and Joint Surg.* Oct., 1959. 41-A:7:1267-1285.

An objective evaluation of 31 patients with congenital abnormalities of the lower extremity who had been treated by amputation; all were seen and cared for at the Area Amputee Center, Grand Rapids, Mich. Patients came from all parts of the state and amputations had been performed in different communities by different surgeons; results of amputation do not, therefore, represent those found in a group treated by one particular method according to a planned program. Congenital abnormalities treated were classified as: absence of the fibula or tibia, abnormalities of the feet, pseudoarthritis of the tibia, abnormality of the proximal part of the femur, and in four patients the abnormalities were unknown. Brief histories of all patients in the group are included, some with illustrations. From the standpoint of prosthetic fitting there were no failures in the group; all were good limb-wearers and performed well with wide variations in excellence of performance. The author believes that amputation, as a reconstructive operative procedure, has a place in the treatment of selected cases of severe congenital abnormalities of the lower extremity.

APHASIA

894. Wood, Nancy E.

Language disorders in children; background and definition, diagnostic approaches, therapy procedures. Chicago, Natl. Soc. for Crippled Children and Adults, 1959. 32 p.

In this monograph adapted from a seminar for professional personnel presented at the 1958 convention of the National Society for Crippled Children and Adults, Dr. Wood, the principal speaker, reported on the results

of a long-term (1952-1960) study at the Cleveland Hearing and Speech Center. Case histories of 1,200 children between the ages of 3 and 6 who had delayed speech and language disorders were examined in a pilot study. To date more than 800 children between the ages of 3 and 9 have received therapy through the Foundation for Children with Language Disorders, an integrated but separate part of the Cleveland Center. Dr. Wood offers some tentative conclusions concerning childhood aphasia, its diagnosis, and therapeutic approaches. Dr. Leroy T. Laase, Chairman of the Department of Speech at the University of Nebraska, discussed Dr. Wood's report of the research project. He emphasized especially the difficulty of diagnosis and the problems of differentiating between receptive and expressive aphasia.

Available from the National Society for Crippled Children and Adults, 2023 W. Ogden Ave., Chicago 12, Ill., at 50¢ a copy.

ARCHITECTURE

See p. 362; 886.

BLIND—DIAGNOSIS

895. Graham, Milton D. *(Am. Found. for the Blind, 15 W. 16th St., New York 11, N.Y.)*

Toward a functional definition of blindness. *New Outlook for the Blind.* Oct., 1959. 53:8:285-288.

Wide variance in estimates of the number of blind persons in the United States, as reported by different agencies, is due to difference in defining blindness. The definition recommended by the U.S. Bureau of Public Assistance is an economic one; that used by the National Health Survey is a functional definition, based on total performance of the blind person. Technical advances in low-vision aids now make it possible to restore usable vision to those considered blind. Research should be concerned with relating the two definitions of blindness in a more meaningful way. The functional definition of blindness has implications for work in the field of services for the blind.

BLIND—PROGRAMS

896. Hunt, Joseph *(U.S. Off. of Voc. Rehabilitation, Washington 25, D.C.)*

Impact and potential of rehabilitation. *New Outlook for the Blind.* Oct., 1959. 53:8:275-280.

In same issue: Services to the blind in historical perspective, McAllister C. Upshaw. p. 281-285.

Rehabilitation services for the blind, supported by the federal government, have contributed greatly toward improvement in the economic status of blind persons. In 1939, statistics show that 162 blind persons were considered rehabilitated as contrasted with 4,007 rehabilitated during 1958. Mr. Hunt reviews changing concepts in rehabilitation of the blind, the practical aspects of research in this field, and factors to be considered in planning future programs.

Mr. Upshaw, Director of Social Services at the Cleveland Society for the Blind *(1958 E. 93rd St., Cleveland 6)*, shows how services for the blind have grown from two distinct sources—the blind person's need for help and the sighted person's need to help the blind. There is still evident the old concept that solutions to problems of the blind are to be found in the manipulation of the environment for the blind. Concrete services are needed but the professional worker also has the responsibility to help the blind determine their own needs and limitations and ways of compensating for the limits that blindness imposes.

Both papers were presented at the 1959 annual convention of the American Association of Workers for the Blind.

BRACES

897. Archibald, Kenneth C. *(525 E. 68th St., New York 21, N.Y.)*

Leg bracing in hemiplegia. *J. Am. Med. Assn.* Oct. 24, 1959. 171:8:1061-1065.

A discussion of the most commonly used types of bracing for the lower extremities and the indications and contraindications for their prescription for adult hemiparetic or hemiplegic patients. When properly prescribed, bracing can aid in ambulation; where improperly chosen, bracing may limit or prohibit walking. Frequent evaluation and adjustment of braces are necessary for the patient to achieve optimum rehabilitation. A case history is included to illustrate the use of bracing in a patient with relatively prolonged flaccidity.

See also 888.

BRAIN

898. Crome, Leonard L. *(Dept. of Pathology, Fountain Hosp., London, England)*

Cortical lesions in cerebral palsy. *Cerebral Palsy Bul.* 1959. 6:22-28.

In same issue: The reticular formation revisited, I. Calma. p. 1-9.

Conspicuous cortical abnormalities revealed at autopsy in patients with cerebral palsy are surveyed briefly. The author suggests that perhaps the most common of these abnormalities is scarring or ulegyria that may affect virtually the entire brain; it is often associated with cavitation. The etiology of cavitation and of sclerosis is quite obscure in most cases; however, most of the author's cases were congenital in origin and often prenatal. In a few cases, it is possible to determine the etiology of the condition (birth injury, meningitis, embolism, etc.) and, in some cases, even possible to set a time limit for the onset of the causative disturbance (microgyria, pachygyria, and, with less certainty, ulegyria). This degree of certainty in establishing etiology is impossible unless one has access to clinical notes carefully and thoroughly recorded.

In the article by Dr. Calma, experimental evidence that the reticular formation is concerned in the regulation of muscle tone and of cortical activity is reviewed. The three main physiological systems that may be distinguished in the reticular formation are discussed, as well as its influence of the cerebral cortex.

CEREBRAL PALSY

899. Woods, Grace E. *(Hortham Hospital, Almondsbury, England)*

Infantile cerebral palsy; helping the parents. *Med. World.* Sept., 1959. 91:3:225-229, 231.

Parents should be informed of the cerebral palsied child's condition, the extent of his handicap, and the need for treatment as early as possible. Easy access to the family physician or to the physician at the clinic should be provided in order that parents may talk over problems arising in care of the child. Home care should be planned to meet both the physical and emotional needs. Disabilities often encountered in the cerebral palsied child are discussed, as well as ways of coping with them. When a child may prove to be mentally defective, parents should be so advised while the child is still young in order that they may adjust to the possibilities of eventual institutionalization of the child. Early diagnosis, planning, and treatment, as well as education of the parents, will aid both the child and his parents in meeting problems that arise during his childhood and adolescence.

Well known in England as an authority in the field, Miss Woods is also the author of *Cerebral palsy in childhood* (see *Rehab. Lit.*, Aug., 1958. #946).

CEREBRAL PALSY—BIOGRAPHY

See 883.

CEREBRAL PALSY—ETIOLOGY

900. Eastman, Nicholson J. *(Dept. of Obstetrics, Johns Hopkins Hosp., Baltimore 5, Md.)*

Obstetrical factors in the etiology of cerebral palsy. *Conn. Med.* May, 1959. 23:5:316-319.

Clinical and experimental observations on the etiology of cerebral palsy, taken from the literature and from the author's experience, point to intrauterine anoxia at varying stages of pregnancy as the cause of brain damage severe enough to result in psychomotor disturbances that resembled those characteristic of cerebral palsy. The experimental work of Dr. Windle and his associates with animals has demonstrated convincingly the role of anoxia in producing neuropathologic changes of cerebral palsy. Prematurity and neonatal asphyxia were shown to have a rate of correlation with cerebral palsy in studies conducted in Denmark. Folic acid and vitamin B12 deficiencies appear to be responsible for congenital malformations. The collaborative program of research sponsored by the National Institute of Neurological Diseases and Blindness should result in more information on the causative factors in cerebral palsy and allied neuropsychiatric disorders.

CEREBRAL PALSY—MEDICAL TREATMENT

901. Ingram, Alvin J. *(869 Madison Ave., Memphis 3, Tenn.)*

Role of intensive physical and occupational therapy in the treatment of cerebral palsy; testing and results, by Alvin J. Ingram, Elizabeth Withers, and Elizabeth Speltz. *Arch. Phys. Med. and Rehab.* Oct., 1959. 40:10:429-438.

Describes an objective test devised to record the development of motor and social behavior in cerebral palsied children. Sixty children selected for admission to the Crippled Children's Hospital, Memphis, were subjected to an intensive program of physical and occupational therapy and their progress studied by testing with the developmental scale that had been in use for seven years. From results obtained, the authors believe that the test can be useful and informative in the selection of patients who can be expected to profit from intensive treatment. In the group tested, two-thirds showed significant improvement. Children showing improvement were between the ages of 2 and 6½ years; all with IQ of 90 or above were improved, gaining new motor and social skills between 2½ and 3 times as rapidly as prior to treatment. Those who improved under treatment have generally continued, following discharge, to develop at the same rate as existed prior to admission to treatment. The activity record form is included in the article.

See also 912; 923.

CEREBRAL PALSY—PROGRAMS

902. Wallace, Helen M. *(U.S. Children's Bureau, Washington 25, D.C.)*

The operation of a register for children with cerebral palsy. *Cerebral Palsy Rev.* Sept.-Oct., 1959. 20:2:7-9.

Functions of a register for patients with cerebral palsy include estimation of prevalence, provision for follow-up, evaluation of case finding, study of provision for services and unmet needs, use in retrospective study of etiology, evaluating effectiveness of services in relation to results in patients, and study of teenagers and young adults' referral for vocational services. Preliminary to the maintenance of a register, two steps are necessary—the promotion of early case finding and the reporting of patients. Also discussed are problems of casefinding and reporting, personnel needed to maintain a register, the need for community cooperation in administering the register, and its location, preferably in the offices of the official crippled children's agency.

CEREBRAL PALSY—PSYCHOLOGICAL TESTS

903. Dunn, Lloyd M. *(George Peabody Coll. for Teachers, Nashville, Tenn.)*

Comparability of Peabody, Ammons, Van Alstyne, and Columbia test scores with cerebral palsied children, by Lloyd M. Dunn and Randall K. Harley. *Exceptional Children.* Oct., 1959. 26:2:70-74.

Three new or revised individual tests of intelligence and one well-established test were compared for usefulness in assessing cerebral palsied children. All tests required only "yes," "no," or pointing response from children being tested. A description of the four tests, procedures of the study, and results are included. The authors conclude that all these tests can be used successfully with cerebral palsied children for predicting school success. Subjects of the study were 20 children with various types and degrees of cerebral palsy who were attending a three-class special unit in one of the Nashville city schools. Sources for obtaining the four tests are included.

904. Hohman, Leslie B. *(Duke Univ. School of Medicine, Durham, N.C.)*

A study of IQ retest evaluation on 370 cerebral palsied children, by Leslie B. Hohman and Donald K. Freedheim. *Am. J. Phys. Med.* Oct., 1959. 38:5:180-187.

Psychological and medical literature offers little conclusive evidence concerning the effects of maturation and growth on the intellectual development of the cerebral palsied. Possible shifts in the first evaluation of IQ can

be assessed by retesting. This paper reports a study of 370 cerebral palsied children, seen at the North Carolina Cerebral Palsy Hospital, who were given IQ retests following a lapse of 6 months to 5 years. Although roughly 25 percent of the group shifted more than 10 IQ points from their original estimates, second evaluations did not appear to alter the original levels for the group as a whole. The smallest percentage of cases shifting in IQ points occurred in the 90 plus and below 50 IQ groups; largest percentage of shifts was found in the 50 to 70 range. It is believed that shift in IQ points, either up or down, is not apparently related to degree of handicap (mild to severe). A description of children in the sample and the methods used are presented, as well as data from the study. The sample used is believed to have been representative of cerebral palsied populations in general.

CEREBRAL PALSY—SPECIAL EDUCATION

905. New York. University. State Education Department

Education of children with cerebral palsy; workshop summary, sponsored by Bureau for Handicapped Children . . . in cooperation with United Cerebral Palsy Association of New York State and New York Institute for the Education of the Blind . . . March 19-21, 1959. Albany, The Dept., 1959. var. paging. Mimeo.

In addition to outlines of workshop group discussions on the educational evaluation of cerebral palsied children, program planning in a one-class setting, meeting needs of the adolescent cerebral palsied, planning for severely handicapped children with normal I.Q., the learning barriers related to neurological impairment (teaching methods and technics), the summary contains two addresses, "Experiential programming for the cerebral palsied child," by Dr. Harold Michal-Smith (see #889, this issue of *Rehab. Lit.*) and "New York State looks ahead in the education of the cerebral palsied," by Dr. Elena Gall. Panel discussions covered prevocational planning characteristics and educational needs of the cerebral palsied child who is mentally retarded.

A limited number of copies are available free from Dr. Joseph Fenton, Workshop Coordinator and Workshop Summary Editor, State Education Dept., University of the State of New York, Albany 1, N.Y.

CLEFT PALATE—NURSING CARE

906. Prinzing, Dorothy M. *(Crippled Children's Div., Univ. of Oregon Med. School, Portland 1, Ore.)*

Cleft palate habilitation. *Nursing Outlook.* Oct., 1959. 7:10:577-579.

As nursing consultant in the Oregon Crippled Children's Division, Miss Prinzing believes that better results can be achieved in cleft palate habilitation if the public health nurse works as a member of the rehabilitation team. As the only member of the medical team to visit the home of patients, the public health nurse can help families develop long-range plans and positive attitudes toward the child and the extended treatment he will require. She can also act as interpreter of the treatment center's program. Some questions the nurse will be asked by parents and problems arising in care of the cleft palate child are discussed.

CLOTHING

907. Bryce, Theodora E.

Self-help clothes for handicapped children. *Canad. J. Occupational Ther.* Sept., 1959. 26:3:83-87.

A project carried out by therapists of the Physical Restoration Centre, Regina, Canada, in cooperation with mothers of the Parents' Group provided instruction in choosing clothing for their handicapped children. Closer cooperation among parents and all personnel of the Centre's staff has resulted in more attention to the development of dressing skills in children under treatment. The essentials of clothing adapted to handicapped children's needs are discussed.

DEAF

908. Frisina, D. Robert *(Hearing and Speech Center, Gallaudet College, Washington 2, D.C.)*

Some problems confronting children with deafness. *Exceptional Children.* Oct., 1959. 26:2:94-98.

The deaf child, in whom auditory sensitivity is so reduced that he cannot readily comprehend auditory symbols through the ear alone, must transpose auditory verbal symbols into visual verbal symbols. The use of vision for conceptual and perceptual purposes is demanded at a much earlier age in the deaf child than in the hearing child. Because language development is directly related to language stimulation, the lack or diminution of auditory reception contributes to long-term learning and language problems for the deaf. Tests of intellectual functioning show that the deaf are not significantly different from the hearing except in the area of abstract reasoning. The effects of deafness are much more basic to the organism than the factor of school placement, the author believes. A better system for conveying the meanings of abstract concepts and subtleties of language is needed.

909. Whetnall, Edith

What is hearing? *Lancet.* Sept. 19, 1959. 7099:403-404.

Hearing is a process that has to be learned, the author believes, and certain psychological and physiological conditions are essential for learning to hear. The infant, not knowing the meaning of sounds or understanding speech, learns to recognize and interpret sounds that are heard loud enough, often enough, and in association with their meanings during the first months and years of life when the infant has a special facility for learning to hear. The deaf child must be provided with listening opportunities comparable to those normal children experience before judgment is passed on his ability to learn to hear and to speak. Such opportunity must be afforded in the early years as learning to hear becomes a more difficult problem for the deaf child with each successive year of age. Suggestions are given for instructing parents so they may help the young deaf child at home.

DEAF—LIP READING

See 882.

DEAF—SPECIAL EDUCATION

910. Mannen, Grace

Conversational language. Washington, D.C., Alexander Graham Bell Assn. for the Deaf, c1959. 22 p.

Written especially to help the young deaf child acquire a vocabulary for his everyday activities and needs, this series of lessons appeared originally in various issues of *Volta Review*. Because of the many requests for the material, the Association has published it in pamphlet form. The lessons should be especially useful to residential school teachers who are attempting to give their students a knowledge of the ordinary sort of conversation that will be expected of them in a hearing world. Use of the material should help to improve spoken language and lipreading; it contains examples of conversational language for use in the schoolroom, social situations, and in business places. The author, an experienced teacher of the deaf and formerly supervisor of the speech department, Nebraska School for the Deaf, now teaches at the Lutheran School for the Deaf in Detroit.

Available from Alexander Graham Bell Assn. for the Deaf, 1537 35th St., N.W., Washington 7, D.C., at $1.00 a copy.

DEAF—SPECIAL EDUCATION—U.S.S.R.

911. Hunt, J. Franklin *(Hamilton College, Clinton, N.Y.)*

Education of the deaf in the U.S.S.R. *Volta Rev.* Oct., 1959. 61:8:356-363, 390.

During a tour of Russia sponsored by the Comparative Education Society in 1958, Dr. Hunt had the opportunity to observe methods of teaching the deaf and hard of hearing. Soviet methods combine finger-spelling, "natural" signs, speech, lipreading, and the use of residual hearing. The completely oral method has been used in the past but was not satisfactory for all children. Several special schools are described and teacher training is discussed. Vocational training is an integral part of the curriculum in schools for the deaf, as it is in schools for the nonhandicapped. The general inflexibility of the Soviet system of selectivity, fixing the deaf child's status at an early age and placing him in a distinct category for the whole of his formal education, is viewed as a disadvantage by American educators. The segregation resulting from the system separates deaf children from normal children at an early age and affords them little opportunity to learn to live with hearing people.

DRUG THERAPY

912. Drake, Miles E. *(735 Pear St., Vineland, N.J.)*

Meprobamate in mentally retarded cerebral palsy. *J. Med. Soc. N. Jersey.* May, 1959. 56:5:256-257.

Because pharmaceutical firms claimed that meprobamate is a reliable and potent drug in the control of spasticity and excessive motor activity, acting without decreasing normal tone or volitional movement, evaluation of the drug's potential was made during a four months' trial at the Vineland State School, New Jersey, an institution for the mentally retarded. None of the 73 patients with cerebral palsy who received the drug showed objective evidence of muscle relaxation. One-third of the patients in the congenital cerebral spastic group showed unfavorable side reactions, as did 13 percent of those in the birth-injured group. There was no evidence of withdrawal symptoms when use of the drug was discontinued. Methods used in the evaluation project are described.

913. Zimmerman, Frederic T. *(11 E. 68th St., New York 21, N.Y.)*

A controlled experiment of glutamic acid therapy; first report summarizing thirteen years of study, by Frederic T. Zimmerman and Bessie B. Burgemeister. *A.M.A. Arch. Neurol. & Psychiatry.* May, 1959. 81:5:639-648.

A report of an experimental study comparing the effectiveness of reserpine (a tranquilizer) with that of glutamic acid (a cerebral stimulant) in producing intellectual and behavioral alterations in mentally retarded children and adolescents. Striking differences were found; the group treated with glutamic acid showed a significant rise in average verbal intelligence quotient while the reserpine-treated group showed only a small rise. Individual variability of response was extremely wide; further study is necessary for the establishment of clinical evidence of value. Favorable action of both drugs, well beyond the limits of personal bias, was evident.

914. Zimmerman, Frederic T. *(11 E. 68th St., New York 21, N.Y.)*

Analysis of behavior patterns following glutamic acid therapy, by Frederic T. Zimmerman and Bessie B. Burgemeister. *A.M.A. Arch. Neurol. & Psychiatry.* May, 1959. 81:5:649-657.

The second in a series of three papers summarizing the results of 13 years' experience with glutamic acid treatment of mental retardation and behavior disorders. Analysis of the behavior patterns of 464 patients treated with glutamic acid for at least six months failed to reveal any particular factors that predetermine success or failure of therapy. Verbal intelligence retest scores showed significant gains, although performance quotients revealed less impressive gains. Reduction in emotional interference was believed to account partially for improvement in intelligence retest scores. The most reliable results are in the realm of behavioral changes following glutamic acid therapy; IQ-point change is only a secondary factor.

EXERCISE

915. Piercy, J. M. *(London Hospital, London, E.C. 1, England)*

Progressive resistance exercise. *Physiotherapy.* Sept., 1959. 45:9:186-190.

A description of the existing types of progressive resistance exercise and research conducted in the hope of improving its application and assessing variations to determine the most effective system. The fractional system of weight-lifting, developed by DeLorme, is based on the 10 Repetition Maximum and was originally called heavy resistance exercise. Improvements were incorporated in the system by DeLorme and Watkins in 1951 when it became known as progressive resistance exercise. Variations advocated by Zinovieff and McQueen are discussed, as well as another method recently adopted by athletes and used to a certain extent in physical therapy.

HEMIPLEGIA

See 897.

HOBBIES

916. Rehabilitation through photography. *Hospitals.* Oct. 16, 1959. 33:20:56-59.

An organization known as Volunteer Service Photographers, Inc., provides instruction in photography as part of the rehabilitation therapy in 40 hospitals, including civilian and Veterans Administration hospitals, mental health institutions, and rehabilitation centers. The organization maintains and supplies photo laboratories especially designed for wheelchair and stretcherbound patients. An annual interhospital contest for student-patient photographers, with cash awards and grand prizes, is another of its activities. Illustrations of volunteer members in action and of prize-winning samples of patients' photographic work comprise the main part of the article.

HOMEBOUND—EMPLOYMENT

917. Clarke, Margaret *(Dept. of Home Care, Montefiore Hosp., 210th St. & Bainbridge Ave., Bronx 67, N.Y.)*

Jobs for the homebound. *Public Health Rep.* Sept., 1959. 74:9:813-822.

A description of a five-year demonstration project in vocational rehabilitation of the homebound, undertaken by the home care department of Montefiore Hospital, New York City. The 85 to 95 patients are maintained at home through close medical supervision with care provided by a medical-social team composed of physicians, social workers, nurses, recreation and art therapists, and physical therapists. Objectives, methods, and organization of the program, characteristics of patients, types of work activities, and individual work plans are discussed. All patients who worked for a year or longer experienced some degree of psychological improvement, primarily reduction of depression. Homework programs for chronically ill homebound patients formerly considered too incapacitated for vocational rehabilitation can be operated at reasonable costs, according to experiences of this project. Eleven percent of the patients worked regularly.

MENTAL DEFECTIVES

918. Symposium on the mechanism and management of mental deficiency in infants and children; Guest editor, I. Newton Kugelmass. *Internatl. Rec. of Med.* Feb., March & Apr., 1959. 172:2, 3, & 4. 3 pts.

Contents: Introduction, I. Newton Kugelmass.—Genetic factors in the etiology of mental retardation, Harold O. Goodman and C. Nash Herndon.—Recognition of mental deficiency in infancy, Olga Bridgman.—Mental subnormality; illusions and directions, Theron Alexander.—(Part II): Chemical therapy of mentally retarded children, I. Newton Kugelmass.—Childhood schizophrenia, childhood autism, and Heller's disease, Clemens E. Benda and Johannes C. Melchior.—Factors in the management of mental retardation, Delton C. Beier.—(Part III): Prognostic difficulties in mental retardation, Brian H. Kirman.—The role of the family physician in the care of the mentally retarded child, Siegried A. Centerwall and Willard R. Centerwall.—Recent developments in the English mental deficiency service, L. T. Hilliard.

Single issues of the *International Record of Medicine* are available from MD Publications, Inc., 30 E. 60th St., New York 22, N.Y., at $1.40 a copy.

MENTAL DEFECTIVES—MEDICAL TREATMENT

See 912; 913; 914; 929.

MENTAL DEFECTIVES—PARENT EDUCATION

919. Tudor, Richard B. *(316 Doctors Bldg., Minneapolis, Minn.)*

What to tell parents of a retarded child. *J.-Lancet.* May, 1959. 79:5:196-198.

The physician must first inform himself in regard to all aspects of mental retardation before he can educate parents to accept and aid the child who is retarded. Diagnosis of the child's condition should be substantiated and the parents informed as soon as possible in a tactful, considerate, and constructive manner. Parents should be protected from the futility of wasting time, emotions, and financial resources. Dr. Tudor believes parents should be advised to keep the retarded child at home, treating him as much as possible as a normal child. The question of institutionalization should not arise except in the case of children with severe brain injury who are either completely flaccid or spastic or overly aggressive. Normal children are not harmed by association with retarded children except in instances where parents' attitudes are unsatisfactory. Parents should always make the decision regarding possible institutionalization; the physician acts only in an advisory capacity.

MENTAL DEFECTIVES—RECORDS

See 885.

MENTAL DEFECTIVES—SPECIAL EDUCATION

920. The slow learner; a . . . special feature. *N.E.A. J.* Oct., 1959. 48:7:19-28.

Contents: The slow learner; an overview, Lloyd M. Dunn.—Administrative plans that help, Merle B. Karnes.—Remedial work in the elementary school, Samuel A. Kirk.—In the secondary school: In the junior high school, Jack W. Birch; In the senior high school, Robert L. Erdman.

This 10-page special feature in the *Journal* is the contribution of authorities in the field of special education. Dr. Dunn defines the slow learner and tells how he may be identified through screening tests. He also discusses characteristics of slow-learning children and what the school can expect of them in the way of achievement. Dr. Karnes outlines certain basic principles to be considered in planning to meet the needs of slow learners. Dr. Kirk names three major objectives in connection with remediation or adaption of instruction for slow learners in elementary schools. Dr. Birch and Dr. Erdman emphasize that programs for the slow learner in the junior and senior high schools should be tailored to meet the problems presented by his learning difficulties and to provide experiences to fit the slow learner for a satisfying life as an adult.

MENTAL DISEASE—EMPLOYMENT

921. Conners, J. Edward *(Harvard School of Public Health, 55 Shattuck St., Boston 15, Mass.)*

A new step in the rehabilitation of the chronic mental patient. *J. Counseling Psych.* 1958. 5:2:115-119.

Describes a pilot project at the V.A. Hospital, Brockton, Mass., for the rehabilitation of chronic mental patients. A work program combining psychological, vocational, and social welfare elements was undertaken for a six-

month period. Twenty chronic schizophrenic patients, with a mean age of 40 and who had been hospitalized for approximately five years, were employed daily by local farmers. Although the group employed was small, results indicated the feasibility of extending the therapeutic community to a realistic work setting within the community outside the institution as a further step in the rehabilitation process. An essential element in the program was the industrial therapist who provided a "significant figure" to whom patients could relate; daily support and encouragement provided by the therapists served as a stimulus for patient work productivity. Development of good work habits, begun in the hospital work activities program, was reinforced. Financial reward also appeared to be of value in providing incentive for work productivity.

MENTAL DISEASE—SOCIAL SERVICE

922. Freeman, David *(Metropolitan State Hosp., Norwalk, Calif.)*

Rehabilitation of the mentally ill aging. *Soc. Work.* Oct., 1959. 4:4:65-71.

A report on an experimental project employing an interdisciplinary team to provide full-scale services on a custodial ward of geriatric patients in a state hospital. Emphasis in the report is on the contributions of social work toward the rehabilitation of aging, long-term patients. Of the 83 patients in the ward, 22 were capable of living outside the hospital; an additional 22 were considered able to attempt to live outside. Social work services were concentrated on these 44 patients. Objectives of the program were to motivate patients to leave the institution, to help them plan for return to their own homes or to go into foster care homes, and to give support to patients on their return to the community. Standard therapies were used intensively by a psychiatric team. When skills of the social worker are closely coordinated with other treatment, patients can be moved out of the hospital into the community.

MONGOLISM—BIOGRAPHY

See 884.

NEUROLOGY

923. Bates, John A. V. *(Neurological Research Unit, National Hosp., Queen Sq., London, England)*

Results of cerebral surgery for motor disorders. *Cerebral Palsy Bul.* 1959. 6:29-32.

Although no operation is currently available to relieve the spasticity of cerebral palsy in childhood, neurosurgeons have been relieving tremor and rigidity in some cases of Parkinson's disease by the surgical destruction of nervous tissue in the cerebral hemisphere. The author reviews six possible explanations for the relief of tremor and rigidity without impairing motor performance. What are now only speculations concerning the results obtained will become more understandable as post mortem studies of the lesions in successful and unsuccessful cases are available.

924. Olson, C. Kent *(825 Nicollet Ave., Minneapolis 2, Minn.)*

Chemosurgery for parkinsonism. *Am. J. Nursing.* Oct., 1959. 59:10:1411-1413.

In same issue: When the patient has chemosurgery, Valborg E. Tollefsrud. p. 1414-1416.

A description of a relatively new procedure used in the treatment of Parkinson's disease to relieve tremor and rigidity. Dr. Olson discusses briefly the syndrome of parkinsonism, preoperative preparation of the patient, the surgical technic itself, and care during the postoperative period, as well as selection of patients for surgery. Miss Tollefsrud discusses physical and emotional problems of the patient with parkinsonism who is to undergo surgery. Nursing problems and technics used in the care of these patients are considered, as well as ways in which the nurse aids in their rehabilitation.

See also 898.

NURSING

925. Zalfas, Irma E. *(71 W. 47th St., New York 36, N.Y.)*

Rehabilitation nursing in a sheltered workshop, by Irma E. Zalfas and Barbara S. Schwartz. *Am. J. Nursing.* Oct., 1959. 59:10:1428-1431.

The authors, industrial rehabilitation nurses for Altro Health and Rehabilitation Services, New York City, describe their duties in the sheltered workshop situation. They are responsible for accident prevention work, clinic nursing, all phases of industrial health, diet supervision, interpretation of individual clients' needs and problems to social workers and welfare investigators, and cooperation with administrators of the workshop. Since the workshop provides services for tuberculous, cardiac, or discharged exmental patients, the nurse must understand the concepts of rehabilitation nursing and be able to work as a team member.

Reprints of the article are available from the Tuberculosis Nursing Advisory Service, National League for Nursing, 10 Columbus Circle, New York 19, N.Y., at 20¢ each.

NUTRITION

926. Kaufman, Mildred *(Div. of Special Health Services, U.S. Public Health Service, Washington 25, D.C.)*

The nutritionist in organized home care, by Mildred Kaufman and Marian S. Bryan. *Public Health Rep.* Oct., 1959. 74:10:873-877.

In same issue: Meals-on-Wheels projects. p. 923-924.

Organized home care programs, developed by many communities and administered by hospitals, agencies such as the visiting nurse association, or local health and welfare department, should include nutrition as one of their essential services. The nutrition consultant should be included in team planning and should be well oriented in the philosophy and objectives of the home care program. She seldom will have direct contact with patients; her responsibility is to educate other personnel working with patients. Dietary guidance is coordinated with other home care services and should be adapted to the needs of the individual home care program. A case history illustrates how dietary guidance was provided a patient under the Philadelphia Home Care Plan.

The article describing Meals-on-Wheels projects shows how this service meets the needs of many of the aged and chronically ill. Improvement in diet often aids recovery

from physical disability. Columbus, Ohio, administers such a project on a voluntary basis; Rochester, N.Y., administers its project through the Visiting Nurse Service on a contract basis for the Bureau of Chronic Diseases and Geriatrics of the State Department of Health.

OCCUPATIONAL THERAPY

927. Blashy, Manfred R. M. *(Phys. Med. and Rehab. Service, V.A. Center, Temple, Texas)*

Orthokinetics; a new receptor facilitation method, by Manfred R. M. Blashy and Renate L. Fuchs. *Am. J. Occupational Ther.* Sept.-Oct., 1959. 13:5:226-234.

Orthokinetics, as yet a little known rehabilitation therapy developed by Julius Fuchs, an orthopedic surgeon of New York, appears to utilize the exteroceptors of the skin and, indirectly, the proprioceptors of the muscles and tendons to excite or inhibit respectively antagonistic pairs of muscles in a reciprocal pattern. The authors describe the method in detail, giving probable causes for the results that it produces. Observations on a series of 100 patients treated by orthokinetics are included. The effects of this therapy include relief of pain, sometimes rapid; improvement of coordination, often immediate; decrease of spasticity, also often immediate; increase of muscle power in facilitated muscle groups; increase in range of motion; muscle reeducation, almost completely automatic; and stabilization of joints. In addition the method is time-saving for both the therapist and patient; it improves morale in patients and helps to shorten the over-all time required for rehabilitation.

See also 881.

OLD AGE—INSTITUTIONS

See 886.

OLD AGE—MEDICAL TREATMENT

928. Markson, Charles A. *(Suite 11, 167 College St., Toronto, Canada)*

An integrated medical service for the aged; a pattern for an active medical program in a hospital for chronically ill and a home for aged as evolved through integration with a general hospital, by Charles A. Markson and Henry A. Himel. *Canad. Med. Assn. J.* May 1, 1959. 80:9:730-733.

Medical services of the New Mount Sinai Hospital, Toronto, were integrated with those of the Baycrest Hospital and Jewish Home for the Aged, a combined home and hospital. Service on a rotating basis at Baycrest is the responsibility of the New Mount Sinai Hospital staff, affording staff an opportunity to participate in an organized clinical and educational program in geriatrics. Facilities of Baycrest and the administration of the program are described.

PARALYSIS AGITANS

See 923; 924.

PARAPLEGIA—MENTAL HYGIENE

See 934.

PARAPLEGIA—PHYSICAL THERAPY

929. Harkins, David C. *(Pineland Hosp. and Training Center, P.O. Box C, Pownal, Me.)*

The team approach in the rehabilitation of a mentally retarded spastic paraplegia, by David C. Harkins and O. D. Carter. *J. Maine Med. Assn.* Apr., 1959. 50:4:118-119.

A review of the case history of a physically handicapped, mentally retarded adolescent admitted to Pineland Hospital and Training School in 1950 for institutional care and training. Spastic paraplegia developed following the surgical removal of a malignant spinal growth. Physical therapist, nursing personnel, pathologist, chief medical technician, and vocational counselor cooperated in his training program. Now 25 years old, he is to be placed in a federal vocational training center in preparation for employment in the community. It is believed that the coordinated program helped this patient to achieve considerable growth and progress.

PARENT EDUCATION

See 880.

PARTIALLY SIGHTED

930. King, R. W. *(1200 N. Walker St., Oklahoma City 3, Okla.)*

The visually handicapped; or are they? *J. Okla. State Med. Assn.* May, 1959. 52:5:302-306.

The University of Oklahoma School of Medicine initiated clinic services to assist the partially sighted in April, 1958. Results have shown that those classified as "legally blind" can often be gainfully employed or can obtain a useful education when supplied with the correct optical aids. Data on 103 patients served during 1958 are included; cases of special interest are reported briefly. In this group there were only six who could not be helped through the provision of optical aids; nine others could have been helped but did not want to make the adjustments called for. Education of the partially sighted child can often be prolonged when optical aids are provided for the magnification needed for reading. Reevaluation of children in sight-saving classes and the provision of aids might permit many partially seeing children to be educated in public schools in their home towns rather than at schools for the blind.

PHYSICAL EFFICIENCY

931. Sokolow, Jack *(400 E. 34th St., New York 16, N.Y.)*

A method for the functional evaluation of disability, by Jack Sokolow (and others). *Arch. Phys. Med. and Rehab.* Oct., 1959. 40:10:421-428.

Legislation establishing the "disability freeze" has made it essential to develop a uniform system for classifying the physical, emotional, social, and vocational capacities of disabled persons in functional terms. A tentative classification devised at the Institute of Physical Medicine and Rehabilitation is described here by Drs. Sokolow, John E. Silson, Edward T. Anderson, Howard A. Rusk, and Mr. Eugene J. Taylor. Procedures and tests that have been widely accepted and are standard for all practical purposes have been incorporated in the system. Results of a pilot test on 124 patients, using the form for recording their

functional capacities, are reviewed. The system appears to be a practical and valid method for rapid, easy recording of statistics used in evaluating functional disability. Information is coded for punching on an IBM "master" card; "detail" cards are used to record those items not given on the master card.

A detailed six-page form used in the classification system may be obtained on request to the author. (For a preliminary report of the project, see *Rehab. Lit.*, Sept., 1958, #1024.)

See also 901; 946.

PHYSICAL EXAMINATIONS

932. Loyd, Earl L. *(515 E. High St., Jeffersonville, Mo.)*

Social security disability program; the physician's role. *Mo. Med.* Oct., 1959. 56:10:1140, 1142.

An explanation of the disability provisions under the Social Security Act, its administration, and the responsibilities of the physician asked to provide a complete medical report on the disabled person applying for benefits under provisions of the Act.

PHYSICAL THERAPY

See 927.

PHYSICAL THERAPY—ADMINISTRATION

933. Rose, Donald L. *(Dept. of Phys. Med., Univ. of Kansas Med. Center, Kansas City, Kan.)*

Safe practices in the physical therapy department. *Phys. Therapy Rev.* Oct., 1959. 39:10:669-673.

A discussion of points to be checked in regard to the safe practice of physical therapy, not only the physical equipment and area of the department, but also the keeping of records and relationships with patients and physicians treating them. In the administration of treatment procedures violations of safety practices are not unknown and should be corrected; often this involves the problem of verbal orders or disagreement on orders given by the physician.

PSYCHIATRY

934. Pisetsky, Joseph E. *(V.A. Hosp., 130 W. Kingsbridge Rd., Bronx 68, N.Y.)*

Electric shock therapy in the treatment of a depressed paraplegic, by Joseph E. Pisetsky and Franklin S. Klaf. *Am. J. Psychiatry.* July, 1958. 115:1:80-81.

A case report of the treatment of a 25-year-old paraplegic patient with a severe depression, suicidal preoccupation, and severe pain unrelieved by drugs or surgery. The patient was able to complete a course of 15 electroshock treatments without complications developing. Some improvement was noted in the degree of depression and a subsidence of suicidal preoccupation; no change occurred in the sensation of pain or the psychological reaction to it. Anectine was used as a muscle relaxant during treatment. There have been no cases of traumatic paraplegia treated by electroshock therapy reported previously in the literature. Before the advent of muscle relaxant drugs, the risks of such treatment were considered too great with paraplegic patients.

PSYCHOLOGICAL TESTS

935. Carpenter, Samuel J. *(Dr. Cottle, 116 Bailey Hall, Guidance Center, Univ. of Kansas, Lawrence, Kan.)*

Test usage in state vocational rehabilitation, by Samuel J. Carpenter, William C. Cottle, and Gerald W. Green. *Personnel and Guidance J.* Oct., 1959. 38:2:128-133.

The authors briefly review previous studies in the literature concerned with current testing practices in guidance and counseling centers; none was found to deal specifically with the use of tests in vocational rehabilitation. A survey was made of 90 state vocational rehabilitation agencies; results are tabulated as to frequency of use of 123 tests listed in the questionnaire. Of the 78 agencies responding, 72 percent indicated they used psychometrists for test administration; 28 percent indicated that a counselor or psychologist within the agency interpreted test results. Findings of the data indicated that the variety of tests used by vocational rehabilitation agencies does not differ significantly from those used in other guidance and counseling agencies as reported in the previous studies.

PSYCHOLOGY

936. U.S. Office of Vocational Rehabilitation

Psychological services in vocational rehabilitation, by Salvatore G. DiMichael. Washington, D.C., Govt. Print. Off. (1959). 53 p.

A new technical bulletin prepared for use by rehabilitation agencies in staff training and program development. Rehabilitation counselors and other professional workers in the field of vocational rehabilitation should be aware of the increasing need for psychological services during the counseling process. The bulletin does not cover technical aspects of psychological measurement and appraisal but gives significant information on the value of psychological services, community resources for securing psychological services for clients, and administrative procedures in setting up psychological services within the rehabilitation agency. Contains a bibliography of 39 selected references for further information on counseling and psychological services in vocational rehabilitation.

Available from U.S. Superintendent of Documents, Washington 25, D.C., at 20¢ a copy.

See also 887.

PUBLIC ASSISTANCE

See 890; 932; 942.

PUBLIC HEALTH NURSING

937. Galkin, Jean DuBois

Public health nursing in chronic disease. *Health News,* N.Y. State Dept. of Health. Oct., 1959. 36:10:4-15.

The public health nurse has an important role in the care of the chronically ill and in the prevention of disability and deformity resulting from such illness. Increasing requests for long-term care in the community and the desirability of home care for the chronically ill call for an evaluation of needs and formulation of policy

by the community nursing agency. The public health nurse should play a more active role in patient care and should assist in research to improve the quality of nursing and to aid in the development of better health services. Because the nurse has a long-term relationship with the patient and his family, she is able to evaluate progress and the need for other services available from community resources.

PUBLIC WELFARE—NEW JERSEY

938. New Jersey. Commission to Study the Department of Institutions and Agencies

The state's organization for social welfare in New Jersey; report of the. . . . Bernardsville, N.J., The Commission, 1959. 128 p. tabs.

A six-man commission was appointed by Governor Meyner in January, 1959, to evaluate the organization of New Jersey's Department of Institutions and Agencies in regard to activities in the fields of mental health, mental retardation, correction, and welfare. The report contains a brief history of state activities in these fields, a description of the current organizational pattern of the Department, and specific recommendations, mainly of an administrative nature, for the improvement of services. A summary statistical report of New Jersey institutions and agencies, as of June, 1959, is included in the appendix, along with a proposed statement of policy for state mental hospitals and a summary of estimated costs of programs under the Department's jurisdiction.

Available from Archibald S. Alexander, Chairman of the Study Commission, Bernardsville, N.J.

RECREATION—PROGRAMS

939. Hill, Beatrice A. *(Natl. Recreation Assn., 8 W. 8th St., New York 11, N.Y.)*

Recreation for the ill, handicapped, and aged. *Recreation.* Oct., 1959. 52:8:334-335.

Many communities with less than 300 long-term chronically ill or handicapped persons have no facilities for providing recreation to those in hospitals and nursing homes or homebound. Mrs. Hill describes a demonstration-and-study project that attempted to determine whether one professional worker can administer services for as many as 300 patients if aided by an adequate well-trained staff of volunteers. Results of the experiment have shown such a plan is feasible on a coordinated, cooperative basis. Organization of the program and recruitment and training methods used with volunteers are described.

REHABILITATION—CALIFORNIA

940. California. Vocational Rehabilitation Service *(State Dept. of Education, Voc. Rehab. Service, Sacramento 14, Calif.)*

A special study; rehabilitations of disabled persons 50 years of age and over. Sacramento, The Service. 1959. (16) p. tabs. Mimeo.

A special report on 256 disabled persons who received vocational rehabilitation services and were rehabilitated during a one-year period from July, 1957, through June, 1958. The group represented 17 percent of the total number of persons rehabilitated during the year. Data are given on age and sex groups, type of disability, welfare status of rehabilitated persons (at acceptance for services and at time of closure of cases), and types of vocational rehabilitation services and their costs. The study illustrates that a substantial number of older workers may be helped to attain self-support when given proper counseling and placement services, in addition to any other services needed for physical rehabilitation. Some of the more difficult cases required two years for successful rehabilitation and placement in a job. A tabular analysis of cases at closure includes data on each individual's age, sex, disability, job at closure, and weekly wage.

REHABILITATION—PERSONNEL

See 887; p. 355.

REHABILITATION—PROGRAMS

941. American Medical Association. Committee on Rehabilitation

The state-federal program of vocational rehabilitation. *J. Am. Med. Assn.* Oct. 24, 1959. 171:8:1107-1109.

A recent survey among physicians selected from a county medical society in a more populous area revealed that many were unaware of services available for the disabled from state rehabilitation agencies. This article explains the development and growth of state-federal cooperation in providing both medical and vocational rehabilitation services. Responsibilities of the medical staff of the state rehabilitation agency are discussed. Mention is made of the research grant program of the Office of Vocational Rehabilitation and the training grant program to prepare more professional personnel in rehabilitation. This is the first of a series of articles to be published for the A.M.A. Committee on Rehabilitation.

REHABILITATION CENTERS—DESIGNS AND PLANS

See p. 362.

SHELTERED WORKSHOPS—PERSONNEL

See 925.

SOCIAL SERVICE—CASEWORK

942. Feider, Leo J. *(Minn. Dept. of Public Welfare, 117 University Ave., St. Paul 1, Minn.)*

Casework in rehabilitation. *Public Welfare.* Oct., 1959. 17:4:145-148, 175-176.

In the Minnesota Work Reorientation Project, sponsored jointly by the Minnesota Department of Public Welfare and Community Research Associates of New York, new methods and technics for shifting the welfare agency focus from "eligibility determination" to "problem-solving" are being tested. The use of casework to achieve rehabilitation goals of welfare clients through diagnosis, planning, implementation, and coordination of services, the author believes, is an essential part of routine operations in the agency. Public welfare should accept the responsibility in spite of the internal and external obstacles put in the way of problem solving. Public welfare services should be rehabilitation-oriented.

SPECIAL EDUCATION—FRANCE

943. Taylor, Wallace W. *(N.Y. Univ. College for Teachers, Albany, N.Y.)*

The education of physically handicapped children in France, by Wallace W. and Isabelle Wagner Taylor. *Exceptional Children.* Oct., 1959. 26:2:75-81.

The fourth article in a series on education of the physically handicapped in countries of Western Europe, it describes the development of special education in France, gives statistics on the incidence of various types of handicaps, discusses provisions made to meet their needs, and considers teacher training and legislation specifically. (For previous articles on special education in Finland, Austria, and Portugal, see *Rehab. Lit.*, July, Aug., & Nov., 1959, #594, 685, and 865.)

SPECIAL EDUCATION—PERSONNEL

See p. 355.

SPECIAL EDUCATION—STUDY UNITS AND COURSES

944. Gallagher, James J. *(Institute for Research on Exceptional Children, Univ. of Illinois, Urbana, Ill.)*

Advanced graduate training in special education. *Exceptional Children.* Oct., 1959. 26:2:104-109.

A summary of the final report accepted by the Division on Teacher Education, Council for Exceptional Children, it suggests minimum standards for developing and administering graduate training in special education. Discussed are admission requirements for students, general program structure and staff requirements, minimum skill requirements in the areas of special education, educational psychology, and curriculum development, and requirements in regard to practical experience. The committee was composed of seven directors of doctoral programs in special education; James J. Gallagher was Chairman.

VOCATIONAL GUIDANCE

945. Farrell, Judith M. *(Maryport Rehabilitation Centre, Mount Martha, Victoria, Australia)*

Occupational therapy assessment by repetitive process work. *Occupational Ther.* Sept., 1959. 22:9:16-17, 28.

Reprinted from: *Bul. Australian Assn. Occupational Therapists.* July-Sept., 1958.

The repetitive workshop has been established as a necessary part of the Centre's medical and vocational assessment services; therapists' reports on patients' performance are used extensively in guidance for placement in outside employment. The author, an occupational therapist, discusses the selection of patients for work trials, the value accruing to patients from repetitive work, its usefulness in evaluating patients' abilities, and the types of jobs included in the unit.

See also 936.

WALKING

946. Bard, Gregory *(2020 Hayes St., San Francisco 17, Calif.)*

Measurement of energy expenditure during ambulation, with special reference to evaluation of assistive devices, by Gregory Bard and H. J. Ralston. *Arch. Phys. Med. and Rehab.* Oct., 1959. 40:10:415-420.

A description of a method for presenting results of energy measurements in the ambulation of both normal and disabled persons. The experimental and graphical procedures have been found of value for recording average energy expenditures in normal subjects, walking at various speeds. These averages can be used for comparison with energy expenditures in the handicapped. This study is especially concerned with ambulation of amputees and hemiplegics, walking with their usual assistive devices. Changes in assistive devices alter the rate of energy expenditure.

(Continued from page 354)

up of his intellectual peers. The presence among the retarded of cranial, facial, and bodily anomalies are additional factors which make parents shy away from enrolling their children in such groups. Even if the appropriate group is found, society makes few allowances for the slow thinker.

"Under such circumstances, it is not surprising that intellectually handicapped children build up hosts of defensive behavior patterns. Retarded children, like the rest of us, may be happy or sad, aggressive or docile, adventurous or timid. Happiness can burgeon into clowning, sadness can become depression, and aggression or docility can become the aim of life; adventurousness easily molds itself into recklessness, and timidity in an incomprehensible world is converted to fear and anxiety. In addition, the stresses upon the parents are transmitted in varying degrees and in varying ways to the youngsters. It is not unusual, therefore, for the slow child to develop a behavior of disorder. Behavior problems in slow children do not indicate that the behavioral aberration is causative, or that it is automatically to be considered secondary. The coexistence of behavior disorder and retarded functioning demands an investigation of the child's developmental history, his parents' attitudes, and his personality attributes to map out the interrelationships of the various factors."—*From* An Introduction to Child Psychiatry, *by Stella Chess, M.D., p. 97-99, 129-130. 1959. Grune & Stratton, 381 Fourth Ave., New York 16, N.Y. $5.25.*

Events and Comments

Reorganization of Rehabilitation Services in Richmond Nursing Home Demonstrates Worth

THE OCTOBER, 1959, issue of the *Virginia Welfare Bulletin* (Dept. of Welfare and Institutions, 429 S. Belvidere St., Richmond 20, Va.) carries an article "Richmond Nursing Home," by Robert L. Gordon, the administrator, on the role played by the rehabilitation program in caring for the disabled. The rehabilitation services at this home run by the city of Richmond have been reorganized as a division and include educational therapy, occupational therapy, physical therapy, and volunteer worker services. Psychiatric consultant services are available. During 1958-59 the average daily population of patients was 248. There were 90,831 days of care; 308 patients were admitted; 185 were discharged as improved; and 147 died during the year. The 1958-59 expenditures totaled $716,712 with a per diem rate of $7.78 compared to an expenditure of $618,329 and a per diem rate of $6.88 in 1957-58. The number of patients discharged increased 20 percent over the preceding year; 82 of those discharged benefited from the rehabilitation services. Beds became available in all categories with no waiting lists. Patients remaining in the home are more active, alert, and interested in self-care and independence than ever before.

Comments on Our Responsibilities in Muscular Dystrophy

"IT IS OUR PHILOSOPHY that while research proceeds with boundless energy to solve the mysteries of muscular dystrophy and thus find the key to prevention, arrest or cure of muscular dystrophy in future generations, we have a medical and moral responsibility to do everything possible for the welfare of the present generations of patients afflicted with this disease. Unfortunately, there is the same widespread apathy toward rehabilitation in muscular dystrophy as there was twenty years ago with respect to cerebral palsy. Although the problems of rehabilitation are constantly changing in a progressive disease, nevertheless a rehabilitation program for dystrophic patients should strive to make the patient as self sufficient as possible physically and vocationally, and provide psychosocial support appropriate to the changing phases of the patient's illness. . . .

"If we as doctors, paramedical professional personnel, parents, friends and teachers have an interest in the muscular dystrophy patients and provide them with the facilities at our disposal, they will gain the inner strength and conviction which will enable them to live fully and happily within the changing limitations of their illness."—*From* Progressive Muscular Dystrophy: Diagnosis and Problems of Rehabilitation, *p. 21-22, 27, by Drs. Chester A. Swinyard, George G. Deaver, and Leon Greenspan. Muscular Dystrophy Associations of America, Inc., 1790 Broadway, New York 19, N.Y. June, 1958.*

JOHPER Adds Section on Intertherapy Relations

A NEW SECTION Intertherapy Relations, now appearing in the *Journal of Health, Physical Education, and Recreation,* will be concerned with therapeutics and adapted physical education, including approaches to the detection of potential conditions and difficulties and their prevention; development; habilitation; rehabilitation; and continuous evaluation. Carl Haven Young, from the Department of Physical Education, University of California, Los Angeles, is the section's editor. In the October, 1959, issue the section ran a condensation of an address given by Dr. Young at the American Association for Health, Physical Education, and Recreation Portland Convention in 1959. The article is titled "An Extending Orbit of Physical Education: Challenges in the Corrective Therapy Profession."

Institute of Rehabilitation Dedicated in St. Louis

IN OCTOBER 1959, the Irene Walter Johnson Institute of Rehabilitation was formally dedicated at the Washington University-Barnes Hospital Medical Center, St. Louis, Mo. Dr. Eric Reiss, assistant professor of medicine and of preventive medicine, is director. Activities will be coordinated through the department of preventive medicine and public health. The $800,000 institute will accommodate up to 100 patients a day.

New York State Names Dr. Fenton Special Assistant in Rehabilitation

DR. JOSEPH FENTON of Albany, has resigned as an associate in the Bureau for Handicapped Children, New York State Education Department, to become the special assistant for rehabilitation to the executive director of the State Interdepartmental Health Resources Board.

Greek Crippled Children's Society Issues 20-Year Report

AN AFFILIATE of the International Society for the Welfare of Cripples, the Hellenic Society for Crippled Children (16 Kononos St., Pangrati-Athens, Greece) has issued an attractively illustrated, well-printed *Summary Report of 20 Years Work for Crippled Children.* The period covered in the report is April, 1937, to April, 1957.

Dr. Beatrice A. Wright Comments on Workmen's Compensation

"THE 'DOLLARS AND SENSE' of vocational rehabilitation is becoming a powerful force in altering the orientation of workmen's compensation systems. It has been suggested that the name 'workmen's compensation' be changed to 'workmen's restoration.' The present, fixed pattern of handling workmen's compensation claims is to move the case as rapidly as possible toward disposition by final award or settlement. The idea of medical care and rehabilitation is almost alien. Rehabilitation of the injured worker and his return to gainful employment has yet to become a basic principle of workmen's compensation; most compensation laws do not require that physical and vocational rehabilitation be provided. The philosophy and practice of present accident and liability insurance mitigates against rehabilitation. All too commonly the monetary advantage to the injured party serves to encourage maximal disability and minimal recovery."—*From* Psychology and Rehabilitation; The Proceedings of an Institute on the Roles of Psychology and Psychologists in Rehabilitation, *edited by Beatrice A. Wright, p. 18. 1959. American Psychological Association, Dept. PAR, 1333 16th St., N.W., Washington 6, D.C. $1.50.*

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